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ABSTRACT

Designed to help social service agencies achieve a comprehensive system of care for chemically dependent pregnant and postpartum women and their drug-exposed children, the model described in this report was developed by a panel of 12 experts in the field of perinatal addiction and drug exposure in infants. The report begins with an overview of general issues central to the discussion of a model of care, and then addresses 10 major themes applicable to all service areas. These themes include coordination of services, staff training and support, cultural sensitivity, access to services, and research needs. A narrative description of the proposed model of care is then presented. The description focuses on five categories: (1) prevention and health education; (2) outreach; (3) health and psychosocial screening and assessment; (4) direct services, including health care, social services, alcohol and drug treatment and recovery services, specific services for drug-exposed children, and services for partners and family members; and (5) case management. Seven appendices make up the greater part of this report. They include: a list of panel participants; a blank and completed matrix describing stages of service delivery, from prepregnancy to 3 years postnatal; descriptions of special populations, including women and children with HIV, and women in jails; a checklist of services; assessment instruments; and a glossary of terms. (MM)

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for Chemically Dependent Pregnant and Postpartum Women and Their Drug-Exposed Children from Birth to Age Three

Laurie A. Soman
Ellen Dunn-Malhotra
Neal Halfon

California Policy Seminar
Technical Assistance Report

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University of California
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INTRODUCTION

Statement of the Problem

Perinatal alcohol and drug use is a major problem for women of child-bearing age, their children, and their families. Existing health and social services, early intervention services for children, and alcohol and drug treatment and recovery services appear inadequate to meet the special needs of women and their children. Professionals in the field of perinatal addiction and drug exposure recognize the need for communities to develop a continuum of services tailored to the specific needs of women and their drug-affected children.

Alcohol and drug use among women is now believed to occur at much higher rates than previously thought. The National Institute on Drug Abuse (NIDA) estimates that 60% of all women of child-bearing age drink alcoholic beverages. During their peak reproductive years (ages 18-34) 10% of all women consume an average of two or more drinks per day, or 14 or more drinks per week, an amount that clearly poses risks to a pregnant woman and her fetus. In addition, NIDA estimates that nearly 10% of all women of child-bearing age use illegal drugs.[1] Estimates of the percentage of women who actually use alcohol and other drugs during pregnancy vary. The California Department of Alcohol and Drug Programs estimates that between 72,000 and 85,000 of the 570,366 live births in the state in 1989 involved perinatal alcohol and drug exposure.[2] The low figure represents the application of the department's estimate of alcohol and other drug use among women of child-bearing age — 12.6% — to the 1989 birthrate, while the upper figure uses a rate of drug use of 14.8% among women of child-bearing age derived from a study in Pinellas County, Florida.[3]

Although increasing numbers of women need alcohol and drug treatment and recovery programs, few are receiving these services. The Institute of Medicine estimates that 10% of the women identified in the NIDA survey as using illegal drugs *clearly* need treatment, and another 20% *probably* need treatment.[4] There is, however, evidence that women are not obtaining treatment for their alcohol and/or drug use. For example, studies report men outnumbering women in treatment facilities at ratios higher than 4:1.[5] A 1987 national study of state-funded alcohol and drug programs found that fewer than 20% of all admissions were for women.[6]

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[1] P.S. Cook, R.C. Peterson, and D.T. Merry, *Alcohol, Tobacco, and Other Drugs May Harm the Unborn* (Rockville, Md.: Office for Substance Abuse Prevention, 1990).

[2] California Department of Alcohol and Drug Programs, *Data Sheet on Perinatal Drug and Alcohol Use* (Sacramento: 1991).

[3] I.J. Chasnoff, H.J. Landress, and M.E. Barrett, "The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida," *New England Journal of Medicine* 322(17): 1202-1206 (1990).

[4] D.R. Gerstein and H.J. Harwood, eds., *Treating Drug Problems: Volume I* (Washington, DC: National Academy Press, 1990).

[5] P.A. Harrison and C.A. Bellile, "Women in treatment: Beyond the stereotype," *Journal of Studies on Alcohol* 48(6): 574-578 (1987).

[6] W. Butynski and D.M. Canova, "Alcohol problem resources and services in state supported programs, FY 1987," *Public Health Reports* 102: 611-620.

Pregnant women find it particularly difficult to find accessible alcohol and drug services. For example, a 1990 survey conducted by the National Association of State Alcohol and Drug Abuse Directors estimates that 280,000 pregnant women nationwide need drug treatment, yet fewer than 11% are receiving these services. Women, including pregnant women, routinely wait weeks, even months, for entry into treatment.[7] Financial barriers and program bias against admitting pregnant women combine to severely limit women's chances for access to services. Chavkin's study of drug treatment facilities in New York City illustrates the impact of these barriers: 54% of all programs surveyed categorically do not accept pregnant women as clients; 67% do not accept pregnant women on Medicaid; and fully 87% do not accept pregnant women on Medicaid who are addicted to crack cocaine.[8] Furthermore, although race and class differences regarding alcohol and drug use appear to be minimal, race and class bias clearly play a role in how women who drink or use drugs may be treated. For example, one study found that African American women are almost 10 times as likely as white women to be reported to child welfare services for drug use.[9]

Few geographic areas have the services in place to address the special needs of women, particularly pregnant and postpartum women, and of their young children. At the same time, we know that pregnancy may provide an excellent opportunity for intervention in a woman's alcohol and drug use since her pregnancy and concern for her newborn often provide compelling motivation to enter treatment.[10] While the literature on women and addiction is growing, there is still no solid body of work on treatment modalities and their outcomes. Yet there does seem to be general agreement in the field on what service components are appropriate for women, as well as evidence that the provision of woman-oriented services increases both entry into and completion of programs.[11] The model of care project was undertaken to address the lack of existing appropriate services by drawing on both the literature and the clinical expertise of a panel of experts to develop a comprehensive model of what services should exist and how they should be organized. The field awaits good studies of these services once they are in place to determine how well they meet women's and children's needs and to what degree they successfully intervene in perinatal alcohol and drug use.

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[7] U.S. General Accounting Office, *Drug-exposed infants: A generation at risk* (Washington, DC: 1990).

[8] W. Chavkin, "Drug addiction and pregnancy: Policy crossroads," *American Journal of Public Health* 80: 483-487 (1990).

[9] Chasnoff et al., op cit.

[10] M. Jessup and R. Roth, "Clinical and legal perspectives on prenatal drug and alcohol use: Guidelines for individual and community response," *Medicine and Law* 7: 377-389 (1988); L. Weiner, H.L. Rosett, and E.A. Mason, "Training professionals to identify and treat pregnant women who drink heavily," *Alcohol Health and Research World* 10(1): 32-35 (1985).

[11] B.G. Reed, "Drug misuse and dependency in women: The meaning and implications of being considered a special population or minority group," *International Journal of the Addictions* 20(1): 13-62 (1985); B.G. Reed, "Developing woman-sensitive drug dependency treatment services: Why so difficult?" *Journal of Psychoactive Drugs* 19 (2): 151-164 (1987); L.J. Bechman and K.M. Kocel, "Treatment-delivery system and alcohol abuse in women: Social policy implications," *Journal of Social Issues* 38(2): 139-151 (1982); D. Kronstadt, *Pregnancy and cocaine addiction: An overview of impact and treatment* (San Francisco, Ca.: Far West Laboratory for Educational Research and Development, Drug Free Pregnancy Project, 1989); B. Tittle and N. St. Claire, "Promoting the health and development of drug exposed infants through a comprehensive clinic model," *Zero to Three* 9(5): 18-20 (1989); M.S. Lawson and G.S. Wilson, "Addiction and pregnancy: Two lives in crisis," *Social Work in Health Care* 4(4): 445-457 (1979); L.J. Beckman, "Treatment needs of women alcoholics," *Alcoholism Treatment Quarterly* 1: 101-114 (1984); A. Rogan, "Issues in the early identification, assessment, and management of children with fetal alcohol effects," *Alcohol Health and Research World* 10(1): 28-31 (1985).

Continuum of Care Model

This report presents the results of the convening of a panel of experts in the field of perinatal addiction and drug exposure in infants. These 12 experts were drawn from different disciplines from across the state, but all share an interest in the needs of chemically dependent pregnant and postpartum women and their children. The panelists were charged with developing a comprehensive model for the care and treatment of these populations of vulnerable women and children that would address health care, alcohol and drug treatment and recovery, social services, and early intervention, as well as critical support services. The model was to be *family-centered*, to address the mother-child dyad as well as the woman's partner and family; to be *comprehensive*, drawing on all the services appropriate to the often complex and multiple needs of these women and children; and to be *coordinated* to draw together multiple services, with direct collaboration among services where possible.

The goals of the model of care are threefold: (1) to provide communities with a model of services and service delivery for women and children affected by perinatal alcohol and drug use ready to be adapted to their locale; (2) to provide a template or overlay by which communities can easily gauge which portions of the continuum of care are present and which still need to be achieved; and (3) to provide communities with a recommended standard of practice for serving these women and children that can be used as a quality assurance tool for judging the capacity of existing or new services to adequately serve these populations.

We chose a developmental perspective for the model, i.e., we asked the panel to consider the appropriate components of care during five stages in women's and children's lives: prepregnancy, prenatal, labor and delivery, women to three years postnatal, and children from birth to age three. We also included women's partners and families for special attention, recognizing the important role they play in women's drinking and drug-use behavior, as well as in their recovery and use of the service system.

In developing this model the panel used as its guiding focus the mother-child dyad and the mutual need of both mother and child for access to appropriate services. This approach supports the views that pregnant women's interests cannot be separated from those of their fetuses and vice versa, that a contrived "maternal vs. fetal" split is both unworkable and ultimately damaging to both, and that children's interests are best served through actions that support development and maintenance of a healthy environment with their biological parents.

Therefore, although we recognize the importance of foster care as an element within the continuum of care, the panel was asked to focus on *biological* families with children either at home or in foster care, rather than addressing services for foster families. The panel was also asked to limit its consideration of children to those aged birth to three years in recognition of the dearth of services for this group of children and the need to develop a consensus on what range of services is appropriate to this age group.

Panel Process

Twelve experts from throughout the state who work in the fields of perinatal addiction, alcohol/drug treatment and recovery, child development, public health nursing, and pediatrics were invited to participate in a one-day conference to develop the model of care. (See Appendix A for the roster of panel members.) The goal of the conference was for participants to clearly delineate the components believed critical to a comprehensive model of services for chemically dependent pregnant and postpartum women and their drug-exposed children from birth to age three.

Each participant was provided with a workbook of materials to provide a framework for developing the comprehensive spectrum of services. The workbook included a syllabus of articles and background material, as well as a series of worksheets to assist panelists to outline the components of the continuum of care. The worksheets, arranged in a matrix form, addressed the full range of services believed necessary for this group of women and children. (See Appendix B for the matrix format we used to organize the panel's work.)

The matrix focused the panel on nine categories of services that from the literature and clinical experience appear to be essential components of a model continuum of care: women's health care, children's health care, alcohol and drug treatment and recovery services, early intervention services, preschool programs, social services, support services, outreach, and public health nursing. Panelists met in small groups in the morning to complete specific service categories for each of the five developmental stages in women's and children's lives (prepregnancy, prenatal, labor and delivery, women to three years postnatal, children 0 to 3), as well as for the category of partners and families. The panel was asked to consider the following topics in completing the matrix:

- the specific services to be included
- the desired location of these services
- coordination of services
- the role of case management
- eligibility for services
- methods for guaranteeing that services reflect cultural diversity and sensitivity.

During the afternoon, each group reported back to the entire panel. This process ensured that all panel members could comment on all components of the model of care. Although one day was very little time to complete the matrices, all panel members worked diligently to achieve the day's goal.

Development of the Model of Care Report

Once the matrix was completed we circulated it to panel members for their review and comment and incorporated their revisions. We then converted the matrix, which is long and too unwieldy to read easily, into the narrative that follows. (The full matrix is included as Appendix C.) In the process, we organized the model components by five major themes: (1) Health Education and Prevention; (2) Outreach; (3) Health and Psychosocial Screening/Assessments; (4) Direct Services; and (5) Case Management. All issues and service components included in the matrix are contained in the more streamlined narrative report. For example, points in the matrix section specific to public health nursing are now incorporated in all five sections of the narrative. Where appropriate, issues specific to chemically dependent women or to drug-exposed children are addressed separately; in general, however, the model components reflect the needs of the mother-child dyad. The model also attempts to recognize and reflect differing schools of thought in the field regarding appropriate intervention, treatment and recovery approaches, and service locations. Thus, the model supports social model approaches to alcohol and drug treatment and recovery, while calling for more intensive medical treatment to be made available where appropriate.

Report Organization

This report describes the continuum of services recommended by the panel of experts and not the opinions of the authors. It begins with a discussion of general themes — underlying issues seen as central to the entire discussion of a model of care. For example, the panel agreed on two basic philosophical positions that inform the entire model:

1. Perinatal alcohol and drug use is a public health, social, and environmental issue; in order to be truly effective, prevention, intervention, and treatment strategies must address this broader context.

2. The term "drug-exposed children" is not appropriate for use as a distinct diagnostic category and should be avoided in favor of a risk model approach that hinges on comprehensive assessments of children and a determination of specific interventions based on those individual assessments.

The section on general themes addresses 10 major themes agreed upon by panel members. These include coordination of services, staff training and support, cultural sensitivity, access to services, and research needs.

The section on the model of care addresses the five model components discussed above and reports the major work of the panel of experts. An additional section (Appendix D) attempts to address some specific service components and approaches for women and children with special needs, e.g., women in jails, women and children with HIV, women with disabilities, adolescents, and children with special health needs. The special needs of these populations are by no means fully covered in this report, however, and deserve additional attention. One population of women that critically needs special attention was not addressed at all in the model: women with dual diagnosis (chemical dependency and mental illness).

The report aims to provide readers with a template for analyzing their existing service system for this group of vulnerable women and children, as well as guideposts for achieving a comprehensive system of care. The development of the model of care for chemically dependent women and their drug-exposed children is, however, only the first step toward assuring that these women and children have access to appropriate services. Communities can use the model to compare their current level of services with an "ideal" array of community-based services. Appendix E includes a service checklist containing the components of the model of care, to assist communities in conducting a basic needs assessment to identify service components still to be established. No single agency can be expected to provide all services noted in the model, indicating the need for community efforts to coordinate both existing and future services. Once communities have identified gaps in services they will have to prioritize their needs, assess their current level of resources, investigate and develop additional sources of funding, and develop a community plan of action specifying the services to be developed.

Limitations of the Model of Care

Although the model of care is based on the knowledge and experience of professionals in the fields of perinatal addiction, alcohol/drug treatment and recovery, child development, public health nursing, and pediatrics, it contains a number of limitations. These result from both the panel's organization and the synthesis of information that was required to produce this document. The limitations include the following:

- The model is based on a one-day consensus meeting of 12 experts and, therefore, reflects the views of this particular panel.
- The description of the model of care reflects analytic reduction by the authors of this report, both in terms of the materials that guided the meeting and in managing the information provided by the panel that resulted in this final document.
- Because of time limitations, not all topics were fully covered.
- In attempting to be exhaustive the report does not reflect the real constraints faced by communities that attempt to provide comprehensive services to chemically dependent women and their children.
- Since the work of the panel was limited to the specific task of describing the model of care, this report does not suggest how communities might prioritize their service needs.
- Although words like "should" and "must" are used throughout this report, reflecting the panel's recommendations, the model is meant only to serve as a guide to communities that attempt to identify gaps in services for chemically dependent women and their children. The model of care is meant to be flexible. Communities will likely find it necessary to adjust the model to their specific needs.

Conclusion

We recognize that the costs of creating and maintaining this continuum of care may be high, and that communities need both the political will and the funding to achieve the model. However, the social and economic costs of *failing* to meet the needs of chemically dependent pregnant and parenting women and their young children are already high and rising. There is consensus in the field concerning which approaches work and are appropriate. We can choose to invest in these approaches now, and hope that this investment will lower both social and economic costs later on, or we can continue to pay dearly as a society for our failure to invest in the health of women and children.

GENERAL THEMES CROSS-CUTTING ALL SERVICE AREAS

The panel of experts that developed the model of care agreed on two broad policy statements that should inform the entire model:

- Service providers addressing perinatal alcohol and drug use, as well as their funders, should avoid use of the term "drug-exposed children" as a distinct diagnostic category and adopt, instead, a risk model that hinges on comprehensive assessments of children and determination of appropriate interventions based on those assessments. Children should not be segregated strictly on the basis of known or suspected prenatal alcohol or drug exposure. Providers should be aware of the limitations of prenatal drug- alcohol exposure as a diagnosis. It may be more appropriate to place young drug-exposed children in either special therapeutic environments designed for children "at risk" for developmental delays or place them into regular school programs rather than isolate them on the basis of prenatal drug exposure. The particular needs of drug-exposed children and their families are more significant factors in determining placement than the single factor of drug exposure.

- Perinatal alcohol and drug use occurs in a social/ environmental context. Individual behaviors are only one factor in this context. In order to be truly effective, prevention, intervention, and treatment services must be designed on the basis of this broader context and use strategies that address social and environmental, as well as individual, factors.

The following themes were generated in the panel's one-day meeting. The themes discussed reflect the focus of the panel meeting, as described in the introduction, as well as the individual opinions of panel members. Not all issues relevant to the delivery of services to chemically dependent women and their children were discussed; many other relevant issues certainly exist.

Coordination of Services

Coordination of services refers to a series of systemic strategies that address the linkages between and coordination of services among programs, agencies, and departments. While coordination clearly affects individual clients, the activities themselves are at the systemic, agency, level. Coordination is acknowledged to be critical in ensuring access to services, and should be pursued across different service and professional disciplines as well as within a single professional discipline, such as between obstetricians and pediatricians. Interdisciplinary collaboration to facilitate client access to services and compliance with case plans can be enhanced through referral networks, shared protocols among all providers, and protocols to assure client followup (such as interdisciplinary case consultation and assignment of primary responsibility for followup) to ensure access for women and children.

Thirty-one California counties now have coalitions for the prevention of perinatal alcohol and drug use with broad public, private, and community membership. These bodies engage in coordination activities including interdisciplinary and cross-agency policy and protocol development and grant-writing. It should be recognized that coordination activities are not free, i.e., they have costs in terms of both agency/program finances and staff time; these costs must be planned for in undertaking coordination activities.

Case Management

Case management involves client strategies that address linkage of services for individuals, and typically includes the following components: (a) intake and outreach; (b) assessment of client needs; (c) development of an individual care plan; (d) brokering of services; (e) counseling and support; (f) advocacy with programs on behalf of the client; (g) monitoring and followup; and (h) evaluation of the care plan's achievement. Panelists felt strongly that professionals involved in perinatal alcohol and drug use should consider renaming case management to avoid any confusion with "enabling" behavior or codependency engendered by the term "management." One alternative suggested was the term "family advocate." Case management, under whatever name, should be available in all programs, and should include the above components to ensure that women and children reach needed services and to act as the effective communication link to professional providers who may be perceived as intimidating.

A single staff person or agency should be identified as the primary case manager for each client; this policy can be implemented through collaborative decision-making among agencies either through a comprehensive policy or on a case-by-case basis (as in interdisciplinary case consultations). One relatively new collaborative model in perinatal alcohol and drug use is the "transdisciplinary model," which brings together representatives of multiple disciplines on treatment teams with a single designated team leader. The team leader has *primary* responsibility for client case management and coordination. This model recognizes the need for input from a variety of disciplines, but minimizes the number of individuals with whom a client must deal. Furthermore, it reduces confusion about agency responsibility for clients and/or turf battles between agencies.

Programs should also consider designating a number of individual staff members to function as case managers. Training, supervision, and ongoing monitoring should be provided to all staff designated as case managers. In order to address the problem of staff turnover, programs should consider developing protocols for providing case management services, as well as resource and referral guides.

Although family needs may change over time, suggesting a need for a change in case managers, ideally a case manager should be involved with a particular family for a minimum of one to two years.

Liaison/Coordination of Services with Home Visitors

Every woman, regardless of her income, should receive at least one home visit during pregnancy and following delivery, so the home visitor can assess the home situation, the woman's health and that of her infant, and their possible need for additional services. A public health nurse, social worker, or other qualified professional could provide this service.

Programs need to develop mechanisms to assure good linkage and coordination with home visitors to achieve the above policy, as well as assure that programs use home visitors when appropriate for followup, case management, health education and promotion, and health care.

Co-location of Services

The term co-location of services is usually used to mean the provision of multiple services in a single site for a client population. Although it is acknowledged as an important concept, it raises complex issues for programs, such as how to achieve co-location and what sites and/or services are appropriate for co-location. Strategies for initiating co-location include (a) establishing central phone numbers for referrals and information concerning perinatal alcohol and drug use, prevention, intervention, and treatment for both women and children; (b) possible co-location of services such as pediatric, family planning, and drug treatment services; (c) use of mobile vans to offer multiple services; (d) co-location of children's developmental programs/therapeutic nurseries on drug treatment program sites; (e) initiating similar or coordinated intake processes among programs serving the same population; (f) data sharing among programs; (g) sharing of client information with the client's consent; and (h) interdisciplinary case consultations.

The Family Resource Center model, an innovative concept under development in some areas, is a more comprehensive approach to co-location. It offers an opportunity to integrate drug-affected families as just one population among other high-risk populations requiring support services that respond to a variety of needs. This model includes a full range of services available on site, including adult and pediatric health care, drug/alcohol services, therapeutic nurseries, parenting classes, case management, mental health counseling, social supports and services, and respite care.

Staff Training and Support

There should be interdisciplinary education (cross-training) of staff of different disciplines and programs, including education on (a) each others' disciplines and roles; (b) the nature of chemical dependency, (c) pregnancy itself; (d) identifying women/children at risk, including women at risk for high-risk pregnancies; (e) early intervention techniques to screen and refer women; (f) use of pharmacologic agents with women who drink/use drugs during pregnancy; (g) early intervention techniques to screen and refer children; (h) basic education regarding child development and parenting; and (i) observational skills useful in working with children and their families.

The state Department of Alcohol and Drug Programs (ADP) has already sponsored a series of cross-trainings focused primarily on perinatal providers, social services staff, and alcohol/drug program staff, and accompanied by followup technical assistance available on request. These trainings, with evaluation and appropriate adaptation, could serve as a model for local training programs. This training should include workers in all fields, including those in perinatal and pediatric health care, child development, early intervention, family planning, social services, mental health, other health/counseling areas, attorneys, judges, probation and parole workers, and alcohol/drug program providers. Finally, alcohol and drug program staff should provide training for prenatal providers on the use of screening and assessment tools for alcohol and drug use.

Professionals addressing perinatal alcohol and drug use should consider developing training and/or experience standards, e.g., standards regarding competence to provide drug/alcohol treatment/recovery services, particularly if these services are to be offered outside traditional drug/alcohol program settings (as in a multiservice center model).

In addition to receiving cross-training, drug/alcohol program staff should be educated on women's issues and treatment and recovery for women. This education can address the historical male orientation of many alcohol/drug programs.

In recognition of the need to avoid staff burnout and to maintain professional effectiveness, program staff should have ready access to ongoing training, supervision, and support to help maintain their participation in the field.

Use of Community Workers

Programs should explore the potential for recruitment, training, and use of community workers who can provide information and support to pregnant and parenting women and advocate on their behalf with needed services. With appropriate training and support, community workers can significantly expand the ability of service programs to reach and serve at-risk women.

Cultural Diversity and Sensitivity

Attention to cultural diversity and sensitivity involves considering methods to guarantee that all programs address cultural differences among clients, including women and children of color and those who are not English-speaking, so that services are appropriate, accessible, and effective. All program staff, including community workers, should receive training in cultural differences, regardless of the staff's cultural background/ethnicity. This training should include sensitivity to different cultures' approaches to family planning, child-rearing, and child development, and must be provided by persons with expertise in the issues and experience in providing such training to multicultural groups. Again, ADP has already experimented with offering training and technical assistance on cultural diversity issues and can assist local programs that wish to provide this training.

In addition, all program staff, including community workers, should reflect the cultural/ethnic makeup of the program's community and client population. Programs should be available in languages other than English; where these services are unavailable, translation services should be provided.

Access to Services

Eligibility

All services on the continuum, including prevention and education, health, support, and outreach, should be available to pregnant and parenting women and women of childbearing age regardless of ability to pay. Those identified as using alcohol and/or other drugs should have access to alcohol and drug treatment programs sensitive to the needs of women and women with children. All children with or at risk of developmental delay should have access to all needed services, including health care, social services, and early intervention, regardless of their ability to pay.

Many prenatal and alcohol/drug programs refuse to take certain women as clients. For example, prenatal programs may refuse to take women who are chemically dependent; drug/alcohol programs may refuse to take pregnant women; drug/alcohol programs may have a formal or informal policy of refusing women who are mentally ill as well as chemically dependent ("dual diagnosis" clients); prenatal as well as treatment and recovery programs may not accept or may be inaccessible for adolescents, women with disabilities, or women with HIV. Finally, women in jails and prisons may have an extremely difficult time obtaining prenatal care and/or alcohol/drug services. Such exclusionary policies, whether official or de facto, set up impossible situations for women who are both pregnant and chemically dependent. Professionals should educate each other on the dangers of these positions and should develop collaborative services that will meet the needs of all chemically dependent pregnant women, including those with additional special needs.

There should be easy access to both Medi-Cal and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/Child Health and Disability Prevention (CHDP) programs by providing:

- presumptive eligibility (eligibility for service beginning immediately on presentation at the program while actual eligibility documentation is being collected)
- continuous eligibility (continued eligibility for program services for a designated time period following the official end of eligibility; for example, providing Medi-Cal eligibility for otherwise ineligible women for 60 days postpartum).

Increasing the Pool of Medi-Cal and EPSDT/CHDP Providers

State legislation should increase provider reimbursement rates to increase the number of providers who accept Medi-Cal and CHDP.

Strategies to facilitate access can also be undertaken at the individual program level by extending program hours to evenings and weekends and/or offering drop-in services, as well as by stationing Medi-Cal eligibility workers on site at health care and other programs to assure immediate enrollment. Programs can also make transportation available to clients, either directly or in the form of bus and taxi vouchers or gasoline reimbursements.

State/Federal Licensing Codes and Local Zoning Rules

While licensing codes assure program quality, strict codes may serve as obstacles to opening new facilities, for example, by preventing programs from offering residential services to women and their children. State licensing codes also may ultimately affect program philosophies, e.g., through licensing categories that may foster a "social" vs. "medical" model dichotomy in drug/alcohol services, or rules that make provision of on-site child care nearly impossible. Licensing codes should be examined and amended if necessary to allow for a broad range of treatment and recovery modalities to be made available through the establishment of new programs for women and children and the expansion of existing ones, while retaining appropriate safety features.

At the local level, zoning rules and processes often result in opposition from neighbors who do not understand alcohol and drug use and fear clients of alcohol and drug programs (the "not in my back yard," or NIMBY, syndrome). Local alcohol and drug programs should work to educate the community and lobby to defuse challenges to programs based on local zoning rules.

Services for Partners and Families

Programs should define "families" broadly, recognizing nontraditional families — including the presence of female partners. Programs should also support women's partners in their recovery efforts, recognizing their influential role in women's drinking and/or use of drugs.

Research Needs

The alcohol and drug and maternal and child health fields should press for more research on a number of key areas: the kinds of drug/alcohol treatment that work for women; the elements of treatment modalities (e.g., how many visits and for what duration of time are needed); the costs and benefits of various treatments; how to identify which women would benefit from which kinds of treatment and recovery services (from less to most intensive); and the reliability of assessment measures. Additional research topics include the impact of different interventions on children who are experiencing or are at risk for developmental delay and the long-term impact of prenatal alcohol/drug exposure on children. Where feasible, research studies should utilize carefully matched samples of women receiving alternative treatments or no treatment (such as women on a waiting list or those who refuse treatment) in order to accurately measure treatment efficacy. There is also a need for more qualitative research, such as intensive case studies or ethnographic interviews with women to examine social, environmental, or cultural contexts and consequences of alcohol and drug use.

MODEL OF CARE

Introduction to the Model of Care

The model of care presented addresses the panel's thinking on the health, social, and alcohol and drug treatment and recovery needs of pregnant and postpartum women and their drug-exposed children from birth to three years of age. Rather than discussing the needs of these populations independently, the model of care focuses on the education and service needs of the *mother/child dyad*, as recommended by panel members. Service needs that are appropriate for only one of the populations, however, are noted in the text. When appropriate, the model notes the needs of women's partners and relevant family members, including parents and siblings, to acknowledge the influence of social relationships on women's alcohol and/or drug use, treatment, and recovery.

The narrative description of the model of care has been organized into five categories: health education and prevention; outreach; health and psychosocial screening/assessments; direct services (health, social services, alcohol and drug treatment/recovery, specific services for drug-exposed children, and services for partners and/or family members); and case management.

Health Education and Prevention

As recommended by the panel, prevention and health education efforts should (1) address the risks involved in using alcohol and other drugs during pregnancy, (2) address the needs of children who have been exposed to alcohol and/or other drugs prenatally, and (3) provide information on how women and children can obtain the health, social services, and alcohol/drug treatment and recovery services they need.

Health education and prevention efforts should be available at a wide variety of community sites including schools, community health clinics, drug and alcohol treatment and recovery programs, community centers, churches, and jails. Education efforts should be targeted to specific at-risk populations (e.g., adolescents, women with HIV infection, children with HIV infection, and women in jails), and tailored to their specific needs. Prevention and health education should be provided by health professionals, such as public health nurses, social workers, and community workers. Educational material must be presented in a positive, nonthreatening, nonpunitive manner.

Education classes as well as information flyers and/or brochures should address the following topics:

- the risks of perinatal alcohol and drug use for women, fetuses, and children and the need for substance-free status when planning a pregnancy
- the physiological impact of drug and alcohol use on women and children

- family planning, including reproductive health education, the risks of unprotected sex (unplanned pregnancy, sexually transmitted diseases including HIV infection), the spacing of pregnancies, and tubal ligation
- sexuality
- nutrition
- pregnancy counseling including adoption, pregnancy termination, and childbirth support
- parenting and child development

  Education should include topics appropriate for all parents (e.g., the need for regular medical check-ups and immunizations, infant care, children's growth and development, developmental milestones, nutrition). In addition, for women who have used alcohol and/or other drugs during pregnancy, education and materials must be specifically tailored to the needs of drug-exposed infants and include additional information regarding, for example, infant withdrawal symptoms, effective methods for soothing agitated infants, the potential effects of alcohol and drugs on children's development, and the value of early intervention services.
- county policies regarding the consequences of alcohol and/or drug use during pregnancy, for example, (1) removal of children from the home, (2) family reunification, and (3) how women can prevent removal of children
- how to access health services such as Medicaid (Medi-Cal in California) and the Early Periodic, Screening, Diagnosis, and Treatment program (in California this is the CHDP, or Child Health and Disability Prevention program); social services such as AFDC, Women, Infants, and Children's (WIC) program and food stamps; and alcohol and drug treatment and recovery services.

Outreach

Communities should develop outreach programs to (1) educate women and men on the consequences of alcohol and drug use during pregnancy and the risks of sexually transmitted diseases, including HIV infection, and (2) promote access to services for both women and their children.

The panel recommends the following outreach activities:

- using billboards, TV, radio, and print media for educational messages, as well as advertising phone numbers of hotlines that provide information and referrals to services, including alcohol and drug treatment and recovery, women's and children's health care, social services, and child development services.
- using community neighborhood workers, cross-trained by professionals, to (1) address issues related to women's health care, family planning, alcohol and drug use, and children's health and development, and (2) referring women and children to alcohol and drug treatment and recovery services, women's and children's health

and social services, and child development services. Ideally, community workers should be available at a wide variety of sites including community health and family planning clinics, WIC program sites, and social service offices as well as schools, churches, storefront clinics, and businesses in order to reach a target population that may not use community health and social services.

- placing eligibility workers from the Department of Social Services at community health and social service sites frequented by pregnant women and women with young children to facilitate women's and children's access to Medicaid, EPSDT, and social services. (This should enable health care providers to maximize reimbursements from Medi-Cal, thereby providing an incentive for providers such as community clinics to make available the needed office space for DSS workers.)

Health and Psychosocial Screening/Assessments

According to the expert panel, health and psychosocial screening/assessments should be a routine part of care for *all* women and children, not only those suspected of alcohol and/or drug use or exposure. The panel noted that medical and psychosocial assessments of women must include screening questions to assess alcohol and drug use, sexual/physical abuse, risk for HIV infection, and psychiatric needs. Examples of screening tools for evaluating alcohol and drug use are found in Appendix F.

Screening/assessments should be completed by a wide variety of health care and other providers offering services to women. Screening/assessments should be provided prior to pregnancy by family planning and other health care practitioners including physicians and mid-level providers (nurse practitioners and physician's assistants), social workers, and alcohol and drug treatment program staff. During pregnancy initial screens should be completed by all prenatal care providers including private physicians, clinics, Comprehensive Perinatal Services Program (CPSP) providers, nurse midwives, nurse practitioners, and physician's assistants, as well as alcohol and drug treatment program staff. Public health nurses may also screen women referred to them during pregnancy. Hospital labor and delivery staff should screen women while they are in the hospital.[12] Comprehensive assessments should follow when indicated by screening results and should be completed by providers trained in both identification and intervention of women at risk.

After delivery and throughout the first three years of a child's life, periodic assessment of the mother/child dyad should be completed by appropriate health providers including physicians, nurse practitioners, public health nurses, physician's assistants, social workers and social service providers, and early intervention specialists to determine needed services. Panel members pointed out that public health nurses are a valuable community resource in that they can provide ongoing home assessments of women, their children, partners, and other family members from pregnancy throughout the first three years of a child's life. Home visits should be scheduled, as needed, either by public health nurses or other professionals, to complete assessments. Early intervention experts should assess children in licensed family day care facilities, preschools, and alcohol and drug treatment and recovery facilities to ensure that children receive comprehensive developmental assessments. In addition, families should be able to self-refer any child between birth and age three for a developmental assessment to determine their children's need for early intervention services.

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[12] A 1990 California law (SB 2669) calls for the development and dissemination of a standardized protocol to be administered in the hospital following delivery in order to identify the needs of alcohol- and drug-affected women and newborns. The protocol now under consideration includes a screening assessment, followed by a more in-depth assessment evaluation for those women flagged by the screening. Both screening and assessment are to be accompanied by referrals to appropriate services including CPS when appropriate.

Assessments should address the mother/child relationship; environmental factors that may affect the mother/child relationship, such as the stability of the home environment, housing, other children and caretakers; the mother's and/or child's involvement with community agencies; and the child's development. Periodic developmental assessments of children by trained providers throughout the first three years of a child's life are essential to identify developmental delays that may not become evident until a child is over 18 months of age, and to promote entry and access to early intervention services. Appropriate referrals, including referrals to Children's Protective Services (CPS) to secure family maintenance services or to remove a child from an unsafe home environment, and to early intervention specialists, should be made based upon the results of completed assessments.

Assessment tools must be well-developed and appropriately used by individuals trained in their administration. Although assessments are generally used to ensure access to needed services for women, children, and family members, they can also restrict access to care by ranking women in need and limiting access to services for those identified as having "less" need. Assessment tools should also be culturally sensitive and appropriate for diverse populations, or they may cause inappropriate referrals or denials of services.

Toxicology screens are not in and of themselves appropriate tools for assessing women's alcohol and drug use during pregnancy. Toxicology screens are not generally used to measure alcohol consumption, but only use of certain illicit drugs. Consequently, they do not provide a full picture of perinatal drug use. Moreover, even for the drugs that are measured, toxicology screens yield information only on women's use at a specific time. Both false negatives and false positives are common. These screens cannot assess a woman's pattern of use, e.g., the range of drugs and/or alcohol used, frequency of use, and changes that occur in alcohol and drug consumption during pregnancy. Such information is essential in determining a woman's need for specific services.

Direct Services

The expert panel recommends that a wide variety of *health, social services, and alcohol and drug treatment and recovery services* be available to women who use alcohol and/or other drugs, their drug-exposed children, and women's partners as well as significant family members. Screening, assessment, and referral services should be available throughout the health and social service systems as well as through alcohol and drug treatment and recovery programs. Ideally, these services should be available to *all* women and children, but they are especially important for women of child-bearing age who may be using, or be at risk for using, alcohol and other drugs, and for young drug-affected children.

Women's Health Care Services

Family Planning

As family planning services may (and often do) provide the point of entry to primary care services for women prior to conception as well as postnatally, they offer an excellent opportunity for identifying women at risk of alcohol and drug problems. These services include a complete health history and comprehensive physical examination, as well as contraceptive education regarding a full array of family planning methods. The physical examination includes screening exams for high blood pressure, blood tests to detect anemia, Pap smears to detect cervical cancer, tests for sexually transmitted diseases (STDs), and instruction in breast self-examination to detect cysts and cancer. A blood test to detect HIV infection should be included if indicated and only with a woman's consent.

Family planning services should be provided not only in health care settings, but in nontraditional settings such as churches, streetfront clinics and housing projects, in order to reach a target population that may not use family planning clinics. Contraceptives that do not require prescription or medical appointment (e.g., condoms, sponges, spermicides) and education regarding their use should be readily available with instructions that are linguistically and culturally appropriate. As the point of entry to primary care, referrals for needed followup for health care should be an integral component of family planning services.

Pregnancy Counseling

Pregnancy counseling should provide women with information on all available options regarding pregnancy, including abortion as well as prenatal care. Counseling should be provided in the context of women's family and community and should address such issues as women's relationships with men, sexual abuse, incest, domestic violence, and codependency. Women's decisions regarding their pregnancies should be supported with an array of community resources. Referrals for care, including prenatal care, should be made in the context of a woman's culture, family, and community.

Prenatal and Routine Gynecological Care

Prenatal and routine gynecological care should be available to all women through a variety of care-givers including CPSP providers, private physicians, physician's assistants, nurse practitioners, and nurse midwives. These providers should screen and assess all women for alcohol and drug use and refer those in need of alcohol and drug treatment and recovery services.

All women suspected of using alcohol and/or other drugs during pregnancy, regardless of their income, should receive a minimum of one home visit. Once women are referred, home visitors (such as public health nurses, social workers, or other trained staff) can perform risk assessments (for alcohol and/or drug use), provide health education and promotion, family planning counseling, prenatal education, childbirth preparation, parenting education, genetic counseling on the potential risks of future pregnancies, and health monitoring, as well as assess the preparations made in anticipation of the child's birth. Home visitors can also provide education for family members on child care and the children's growth and development.

Labor and Delivery

Services provided during labor and delivery should take into consideration women's alcohol and/or drug use. *With a woman's consent* alcohol and drug treatment and recovery program staff and providers of health and/or social services should notify the delivery team of a woman's alcohol and/or drug history. Nonmedical assistance and support should be available to all women (including those incarcerated) who lack a partner, family member, or friend to support them throughout labor and delivery. This assistance can be provided by specially trained community workers (doulas), nurses, or social workers.

The Postpartum Period

Following delivery, social support and modeling should be available to facilitate mother/infant bonding. Hospital staff should develop a postdelivery service plan including discharge planning for the mother and child. They should consider delaying discharge for women identified at high risk for child abuse or neglect to provide time for medical and psychosocial assessment of the mother and child. In these cases, a case conference should be scheduled and attended by a transdisciplinary team including medical personnel, hospital social workers, alcohol and drug treatment and recovery program staff, and, if identified, the mother/child's case manager. A treatment plan for both mother and child should be developed to include: the best alcohol and drug-treatment modality and plan for (re-)entry into a specific alcohol and drug treatment and recovery program; social support services; housing needs; early intervention services for the child; and, if appropriate, referral to Child Protective Services. If a case manager is not involved, one should be assigned to ensure that referrals to services are completed, to coordinate service delivery, and to provide followup regarding implementation of the treatment plan.

Home visits should be made to at-risk women identified prior to delivery or during labor and delivery by hospital staff. Home visitors can coordinate with hospital staff to ensure that women receive postpartum home visits to provide education on infant care and to monitor infants' health and the care provided to women as well as to partners and other family members. Home visitors can link women to family planning services and medical care for unresolved health problems identified during pregnancy or birth (e.g, genetic counseling, chronic diseases such as diabetes); to alcohol and drug treatment and recovery programs; and to any other services required by women and/or their partners and families. Home visitors may also serve as a resource for alcohol and drug programs by providing health education classes for women and their partners on topics that may include family planning, sexually transmitted diseases, and the risks of HIV infection. Public health nurses, social workers, or other qualified professionals could fill the role of home visitors.

Alcohol/Drug Treatment and Recovery Services

There are a number of treatment and recovery models, all of which should be available to allow women to select one that best serves their personal orientation and needs. The following list provides a brief description of each treatment and/or recovery method.

Aftercare and relapse prevention, including 12-step groups. Regularly scheduled recovery support groups using the Alcoholics Anonymous model (self-help oriented, voluntary, no official or professional leader) for women in recovery, children of alcoholics/addicts, and codependents.

Intensive day treatment. Structured therapeutic services, including individual and/or group counseling, provided for a specified number of hours per day (usually 4–8) in an alcohol/drug program setting.

Inpatient programs. Hospital-based alcohol/drug treatment services usually provided for 21–28 days.

Methadone maintenance for pregnant women. Provided in a structured program setting for heroin-addicted women, the program should include counseling on prenatal and postnatal issues including breast feeding, the need for abstinence from alcohol and/or drugs other than methadone, and the potential for ultimately becoming completely drug-free.

Outpatient services. Individual and/or group therapeutic/counseling services provided from one to more hours per week in alcohol/drug treatment and recovery program.

Residential care. Alcohol/drug treatment and recovery services provided in a 24-hour residential setting for women and/or women with their children; residential care usually lasts six months to one year.

Therapeutic communities. Alcohol/drug treatment and recovery services provided in a 24-hour residential setting for women and/or women with their children; community is alcohol/drug free; usually lasts 18–24 months.

Therapeutic support groups. Regularly scheduled recovery support groups with professional leaders for women in recovery, children of alcoholics/addicts, and codependents.

Services should not only accommodate women but be sensitive to their unique needs and those of their children. For example, confrontational strategies traditionally employed in male treatment programs may cause women with low self-esteem to withdraw even more. Alcohol and drug treatment and recovery programs, whether they are provided onsite or through linkages with other community providers, must provide the full spectrum of services specific to the needs of women. Such services include individual therapy and/or support groups that focus on issues such as sexual assault/abuse, domestic violence, codependency, family planning, education regarding pregnancy, childbirth, parenting, and child development. Job training, counseling and opportunities to acquire a General Education Degree (GED, or high school equivalency) are essential components of alcohol and drug treatment and recovery programs.

Program staff should ensure that all pregnant women are enrolled in prenatal care. Public health nurses or other service providers could serve as an effective bridge between alcohol/drug treatment and recovery programs and prenatal care providers. A labor and delivery plan should be developed for every pregnant woman in treatment, and *with her consent* should be shared with her prenatal care provider and her child's health care provider. A tour of the labor and delivery area at the hospital may greatly reduce women's anxiety and increase her trust of the hospital staff. During pregnancy a woman's detoxification (physiological withdrawal) should be of special concern. Management of physiological withdrawal can occur in a variety of settings and the appropriate setting should be determined on a case-by-case basis.

Alcohol and drug treatment and recovery services should be available to women beyond the treatment phase to help prevent relapse and to provide continued support as women cope with the stress of child-rearing. In addition, the impact of alcohol and/or drug using partners on women's long-term treatment and recovery must be addressed, as must the need of some women to separate from their partners.

Drug and alcohol programs must address the needs of their clients' children, and should make onsite child care available. Residential treatment programs for women and for women with children must be part of the range of alcohol and drug treatment and recovery services available. Staff of these programs should assure that children are receiving appropriate medical care, including immunizations and routine well-baby checks. Referrals should be made if children are not receiving adequate medical care. Early intervention services should be available for children, either on site or through referrals to community programs.

Social Services

A full range of social and support services should be available to women before, during, and after pregnancy. These services should include:

- Pregnancy counseling including adoption, pregnancy termination, childbirth support
- Counseling, including grief counseling, as needed, regarding adoption, abortion, miscarriage, stillbirth, loss of partner, etc.
- Linkage to Medi-Cal, CPSP, CHDP, and other health services for women and children
- Case management
- Family violence services
- CPS services (either voluntary or involuntary) including guidance, family maintenance, foster care, and family reunification
- Parent support services including taped phone information lines, hot/warm lines, and advice lines
- Child care including drop-in and respite care

- Transportation to needed services
- Services to support and enhance self-esteem
- Economic support services such as General Assistance and AFDC (available before pregnancy, if a woman has other children) and advocacy to assist in collecting child support
- Financial and daily living skills training
- Vocational rehabilitation services, GED assistance, job counseling, and training
- Housing assistance, including transitional and long-term housing that is clean and sober screening
- Immigration and Naturalization Service (INS) information
- Legal services and advocacy

Services for Alcohol- and Drug-Exposed Children

Children who have been exposed to alcohol and/or other drugs *in utero* require ongoing well-child health care, including immunizations, by providers who have consistent relationships with the children and who can provide a "medical home" for each child. Each child should also have a "medical passport" containing all medical and relevant psychosocial information to ensure continuity of care and followup, particularly for children who may be in and out of the foster care system or may be seeing a variety of providers. Health professionals should consider making contracts with mothers (and partners) to increase the likelihood of parental compliance. Early enrollment of children in Medi-Cal, CHDP, CCS, or a regional center should be facilitated when appropriate.

Since drug-exposed children are at risk for developmental delays, additional services are needed. If women are suspected of alcohol and/or drug use during pregnancy, pediatric exams of the newborns should occur in the hospital shortly after birth as well as three to four days later to identify withdrawal symptoms. If a child demonstrates withdrawal symptoms, physicians, nurses, public health nurses, or nurse practitioners should work with parents so they understand how to care for their infant. Ideally, a minimum of 10 home visits during the first six months of life, and monthly visits until 12 months of age, should be scheduled. Public health nurses or other appropriate professionals such as infant development specialists can perform comprehensive developmental assessments; assess children's feeding patterns including fluids, food, nutrition, and elimination; monitor children's sleep patterns; and monitor children to ensure that they receive ongoing medical care. They can also monitor and assess mother/child interactions; provide models of effective parenting and educate parents regarding child development and developmental milestones; assess the family support network and the mothers' social and living skills; and refer mothers and/or children to providers or services as needed. Home visits should be scheduled less frequently after the first year of life, but should continue through the children's third birthday. This will enable ongoing monitoring of children's physical, cognitive, and emotional development.

Early intervention services should begin soon after birth in the hospital or at home to promote parent/infant bonding.[13] Since all alcohol and drug-exposed children are at risk for developmental delays, periodic and intensive physical and developmental examinations must be performed to identify developmental delays so that interventions are designed and implemented as soon as possible. Early intervention or child development specialists should be available to all alcohol and drug treatment program staff and women enrolled in the programs.

Early intervention services should be provided either at home or in center-based infant development programs. These programs must address cognitive difficulties as well as emotional problems (which are often relegated to secondary status). Services should be provided by an interdisciplinary/transdisciplinary team with one identified primary intervener. The provider-to-child ratio should be as low as possible and if necessary should be 1:1 or l:2. Early intervention programs must involve mothers (partners and families) and address environmental factors that affect children's development.

Support services for parents must be available, including support groups to discuss children's health and behavior problems. Transportation and child care, including respite and drop-in child care services, should also be available to families in order to facilitate access to children's services. Drop-in and respite child care are essential to ensure that families can cope with the stresses of child-rearing. Families should be assessed periodically to determine whether referrals to Child Protective Services are required, either to secure family maintenance services or to remove children from unsafe home environments and place them in foster care.

Enriched preschool programs should be available to children between the ages of 2 and 4. These "Jump Start" programs can fill the gap in services that generally occur for children between the ages of three and four when they become eligible for and can transition into Head Start programs.

Services for Partners and Families

Partners and other significant family members need to be acknowledged and recognized as having significant impact on women's life styles, drinking, and drug-use patterns. A family service plan should be developed to address the needs of partners, grandparents, and siblings and to link partners and/or family members to needed services. Partners, significant family and friends should be welcome to participate in appropriate phases of women's care. Although male partners should be provided incentives to participate, it may be more productive for both women and men if men are educated separately from women on topics that include woman's health and reproduction, family planning, and the dangers of prenatal exposure to alcohol and other drugs, domestic violence, and codependency. Support groups and classes for families should be available during alcohol and drug treatment and should continue after treatment is completed in order to offer support as well as alcohol- and drug-free activities.

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[13] Efforts should be made to provide early intervention services through an expansion of successful existing programs before new programs are developed.

Case Management

Panel members recommended access to case management services, preferably with one identified case manager, for pregnant and postpartum women who use alcohol and/or other drugs, as well as for their drug-affected children.

Case managers should work closely with clients who need support to gain access to health, social, and support services, and should transmit relevant information to child health care providers. Case managers should ensure completion of referrals to drug treatment programs, prenatal care, early intervention programs and other children's services, and CPS when appropriate. They should be present during discharge planning case conferences following delivery in order to participate in assessing the client and developing an appropriate service plan. Case management should continue until children are three years old to ensure that they receive periodic developmental assessments to identify developmental delays that may occur after 18 months. Counseling for mothers, partners, and family members can be provided by case managers and should include discussions regarding the management of children's withdrawal symptoms as well as preparing women for reunification with children who have been in foster care.

To enable better coordination of services, women should be encouraged to sign consent forms enabling providers to release relevant information to other providers. This would facilitate communication and joint planning among providers. Consents should, however, protect women's rights to privacy and restrict access to information they deem confidential, in keeping with federal regulations governing the sharing of client information by alcohol and drug treatment and recovery programs.

Case managers can develop and implement a family plan to coordinate services with other providers including drug and alcohol treatment and recovery programs (for women and partners), social services, prenatal care providers, children's services, and GED assistance, and can make referrals as needed.

APPENDIX A

PANEL ROSTER

Model of Care Panel Members

March 1, 1991

Marlene Cheatham has worked in the field of perinatal addiction for 11 years. Until recently she was program director for the Orchid Women's Recovery Center, and currently is a consultant for Alameda County Options for Recovery Perinatal Pilot Project.

Shirley Collier has worked in health care for 19 years, 12 as a hospital staff nurse. For the last seven years she has worked in the substance abuse field, and is presently director of the perinatal program at the Women's Alcoholism Center in San Francisco.

Karen Finello, PhD, is a developmental psychologist and clinical assistant professor of pediatrics at the University of Southern California, with experience in program development and evaluation. Professor Finello directs a High Risk Infant Follow-Up Program in Los Angeles.

Neal Halfon, MD, MPH, formerly director of the Center for the Vulnerable Child at Children's Hospital Oakland and an associate clinical professor in both the UC Berkeley-UC San Francisco Joint Medical Program and the School of Public Health at UC Berkeley, is now an associate professor at UCLA, holding joint appointments in the School of Public Health (Department of Community Health Sciences) and School of Medicine.

Kathryn Hall, MPH, is a poet, activist, and community health administrator. The last 20 years of her professional and spiritual life have culminated in The Birthing Project, a community-based organization that supports and assists in empowering women to manage their own lives.

Marty Jessup, RN, MS, is immediate past president of California Advocates for Pregnant Women, an organization for women who use alcohol and/or other drugs. She is also an assistant clinical professor of nursing in the Family Health Care Nursing Department at the University of California, San Francisco, and teaches maternal and child health issues in alcohol and drug use in the Perinatal Substance Abuse Pilot Projects in California for pregnant and parenting women who use alcohol and/or other drugs.

Vicki Kropenske, PHN, is director of Outreach Training, a program in the Department of Pediatrics, UCLA, aimed at training professionals who are treating chemically dependent families. She has been working in the area of high-risk maternal-child health for 20 years.

Anthony Puentes, MD, medical director for the Santa Clara County Health Department's Bureau of Substance Abuse Services, heads a comprehensive outpatient treatment program for pregnant and postpartum substance abusers and their infants. Dr. Puentes is currently the principal investigator of a five-year OSAP Model Demonstration Project for pregnant and postpartum women and their infants.

Nika St. Claire, MS, has worked in the field of perinatal addiction in California for 12 years. She currently is director of the Center of CARE, a model infant-parent program for drug-exposed infants and their chemically dependent parents.

Mildred Thompson, MSW, is director of The Healthy Infant Program, a Highland Hospital case management program for drug-exposed infants. Ms. Thompson is a faculty member at San Francisco State University and a member of several voluntary organizations, including the California Black Infant Leadership Committee, Select Committee on Perinatal Alcohol and Drug Abuse, and the Bay Area Consortium for Quality Health Care.

Sylvia Villarreal, MD, is director of the Kempe Clinic at San Francisco General Hospital, which addresses the special needs of children who fail to thrive, infants of adolescent mothers, and drug-exposed infants. A bicultural and bilingual team approach is used to give a well-rounded model for caring for both the parents and their infants.

Judy Williams, MSN, is a public health nurse specialist with Santa Clara County Public Health Nursing, a women's reproductive health nurse practitioner, and an instructor of N-CAST. Ms. Williams was project manager for the University of Washington/Robert Wood Johnson Preterm Infant Research Project, and helped write the California Nurses Association "Nursing Standards for Early Intervention Services for Children and Families at Risk."

APPENDIX B

MATRIX FORM

MATRIX

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
WOMEN'S HEALTH CARE						
PEDIATRIC HEALTH CARE						
ALCOHOL/DRUG SERVICES						
EARLY INTERVENTION SERVICES						
PRESCHOOL						
SOCIAL SERVICES						
SUPPORT SERVICES						
OUTREACH						
PUBLIC HEALTH NURSING						
OTHER						

APPENDIX C

COMPLETED MATRIX

MATRIX I: WOMEN'S HEALTH CARE

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
WOMEN'S HEALTH CARE	*Services* • woman's prevention education and health maintenance education on site in women's health care settings: -- risk of PADU and alc/drug free status when planning pregnancy --family planning education incl. reproductive health education and risks of unprotected sex (unplanned pregnancy, STDs, HIV), nutrition, and sexuality. --D/A education on natural history on chemical dependency in women incl. physiological impact --information on how to access alc/drug treatment and recovery services	*Services* • woman's prevention education and health maintenance education on site in women's health care settings: -- risk of PADU and alc/drug free status when planning pregnancy --family planning education incl. reproductive health education and risks of unprotected sex (unplanned pregnancy, STDs, HIV), nutrition, and sexuality. --D/A education on natural history on chemical dependency in women incl. physiological impact --information on how to access alc/drug treatment and recovery services	*Services* • social support during labor and delivery to be available to all women (incl. those incarcerated) • social support to facilitate mother-child bonding • assessment of mother/child dyad to determine needed services --support services for mother --social/ environmental factors (home/apartment, other siblings, other caretakers, other agencies involved with family)	*Services* • woman's prevention education and health maintenance education on site in women's health care set-tings: -- risk of PADU and alc/drug free status when plan-ning pregnancy --family planning education incl. reproductive health education and risks of unprotected sex (unplanned pregnancy, STDs, HIV), nutrition, and sexuality. --D/A education on natural history on chemical dependency in women incl. physiological impact --information on how to access alc/drug treatment and recovery services		*Services* • significant family and friends, including male and female partners, to be welcomed to participate in all phases of women's care; male partners to be provided incentives to participate • men should be educated separately from women; education should include information on woman's health and reproduction, family planning, and the dangers of prenatal exposure to alcohol and other drugs, domestic violence, and co-dependency

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MATRIX I Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
WOMEN'S HEALTH CARE	• overall psychosocial assessment of all women receiving health care to include screening questions for alc/drug use, sexual/physical abuse, and psychiatric needs and referral to needed services	• education of women at risk about specific county policies re: removal of children, reunification, etc., and information/ counseling on preventing removal of children • medical and psychosocial assessment of all women receiving health care to include screening questions for alc/drug use, sexual/physical abuse, and psychiatric needs and referral to needed services	• hospital staff to develop service plan incl. discharge planning for mother and child: --consider delayed discharge for high risk women to provide time for assessment and early intervention incl. assignment of case manager • coordination with CPS when appropriate	• overall psychosocial assessment of all women receiving health care to include screening questions for alc/drug use, sexual/physical abuse, and psychiatric needs and referral to needed services • ob/gyn, routine medical care, and parenting educa-tion classes • coordination with CPS when appropriate, including counseling to prepare for reunification for women with children in foster care		

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MATRIX I Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
WOMEN'S HEALTH CARE	• at least one case management position on-site in primary care sites to work closely with clients who need additional support to access other health, social, and support services and ensure completion of referrals to drug treatment programs • family planning services, including community outreach, to be provided in a number of non-traditional settings including churches, street-front clinics, housing projects, etc. to reach a target population that often does not use family planning clincs	• at least one case management position on-site in primary care sites to work closely with clients who need additional support to access other health, social, and support services, ensure completion of referrals to drug treatment programs, and ensure referrals to OB providers • family planning services, including community outreach, to be provided in a number of non-traditional settings including churches, street-front clinics, housing projects, etc. to reach a target population that often does not use family planning clincs		• family planning services, including community outreach, to be provided in a number of non-traditional settings including churches, street-front clinics, housing projects, etc. to reach a target population that often does not use family planning clincs --condoms, sponges, spermicides (nonprescription contraceptives) and education regarding their use, incl. STD prevention, should be available, as use does not require prescription or medical appointment		

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MATRIX I Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
WOMEN'S HEALTH CARE	--condoms, sponges, spermicides (nonprescription contraceptives) and education regarding their use, incl. STD prevention, should be available, as use does not require prescription or medical appointment	--condoms, sponges, spermicides (nonprescription contraceptives) and education regarding their use, incl. STD prevention, should be available, as use does not require prescription or medical appointment		--pregnancy counseling to provide women with info. on all legally available options and spacing of pregnancies; referrals for prenatal care alternatives should be made; women's decisions regarding pregnancy outcome should be supported with an array of community resources; counseling should be in the context of woman's family and community and should also address such issues as relationships with men, sexual abuse, incest, domestic violence, co-dependency		

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MATRIX I Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
WOMEN'S HEALTH CARE	--pregnancy counseling to provide women with info. on all legally available options and spacing of pregnancies; referrals for prenatal care alternatives should be made; women's deci-sions regarding pregnancy outcome should be supported with an array of community resources; counseling should be in the context of woman's family and community and should also address such issues as relationships with men, sexual abuse, incest, domestic violence, co-dependency	--pregnancy counseling to provide women with info. on all options, incl. abortion if appropriate, and alternatives regarding prenatal care		• at least one case management position on-site in primary care sites to work closely with clients who need additional support to access other health, social, and support services, ensure completion of referrals to drug treatment programs, and ensure transmittal of important information to child health care providers		

MATRIX II: CHILDREN'S HEALTH CARE

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN O TO 3	PARTNERS AND/OR FAMILY
CHILDREN'S HEALTH CARE					*Services* • provide comprehensive periodic assessments according to CHDP periodicity guidelines; assess physical, emotional, and developmental needs of child, mother-child relationship, and family changes • educate parents regarding need for regular medical check-ups of child; consider contracts with parents for compliance • offer parent support groups re: children's health and behavior problems • coordinate with EI, regional centers, 99-457 programs, and other services to ensure access	

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MATRIX II Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	PARTNERS AND/OR FAMILY
CHILDREN'S HEALTH CARE					• assure continuity of care for child through consistent relationship with health care provider and provision of "medical home" for child • provide case management and close follow-up for children *Access* • institute one record for children with all client information contained ("medical passport" con-cept) • make transportation and child care available for families to access children's health services	

MATRIX III: EARLY INTERVENTION SERVICES

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
EARLY INTERVENTION SERVICES					*Services* • all children to be assessed for developmental delays at regular intervals by trained providers --continuous evaluation to promote entry and access to services at all ages since needs may not be evident until children are over 18 months --general assessments and referral to EI experts to be completed by trained pediatricians, NPs and PAs --other professionals (to include social workers, WIC and AFDC eligibility workers, alcohol/ drug treatment staff) to be trained to screen and refer children --EI experts to assess children in licensed family day care facilities, preschools and alcohol/drug treatment facilities	

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MATRIX III Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
EARLY INTERVENTION SERVICES					• services to begin soon after birth, in the hospital or at home, to promote parent-infant bonding • education for mothers to be specific to the needs of at-risk babies, focusing on infant care, developmental guidance, and well-baby care; education to be provided in non-threatening, non-punitive manner • respite care, drop-in child care, and home visits should be provided based on family needs • EI services to be provided either at home or in center-based infant devel-opment programs • services to be provided by multi-disciplinary team with one primary inter-venor • provider to child ratio should be as low as possible , eg 1:1 or 1:2	

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MATRIX III Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN O TO 3	MALE PARTNERS AND/OR FAMILY
EARLY INTERVENTION SERVICES					• "Jump Start" preschool programs to be available from 2 weeks to 4 years, with transition into Head Start programs, to reach children at earlier ages and to avoid gaps in services from ages 3-4 • EI programs to address emotional difficulties along with cognitive problems, to avoid emotional problems relegated to secondary status • EI programs should involve parents in order to identify environmental factors that affect child's development *Access* • families to be able to self-refer at any point for assessment and EI services • institute one record for children with all client information contained ("medical passport" concept)	

...cont.

MATRIX III Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	MALE PARTNERS AND/OR FAMILY
EARLY INTERVENTION SERVICECS					• services to be provided through an expansion of successful existing programs, and, secondarily, through development of new programs	

MATRIX IV: ALCOHOL/DRUG SERVICES

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN O TO 3	PARTNERS AND/OR FAMILY
ALCOHOL/DRUG SERVICES	***Services*** • women's prevention education and health maintenance education on site in D/A programs: -- risk of PADU and alc/drug free status when planning pregnancy --family planning education incl. reproductive health education and risks of unprotected sex (unplanned pregnancy, STDs, HIV), nutrition, and sexuality. -D/A education on natural history on chemical dependency in women incl. physiological impact --information on how to access women's health care services	***Services*** • women's prevention education and health maintenance education on site in D/A programs: -- risk of PADU and alc/drug free status when planning pregnancy --family planning education incl. reproductive health education and risks of unprotected sex (unplanned pregnancy, STDs, HIV), nutrition, and sexuality. --D/A education on natural history on chemical dependency in women incl. physiological impact --information on how to access women's health care services	***Services*** • communication to labor and delivery team on woman's D/A history (with consent), with protocol for discharge planning, case conferences to determine best treatment for woman • coordination with CPS when appropriate, including in discharge planning case conferences • development of re-entry plan for woman post-delivery, to D/A program, housing, etc	***Services*** • women's prevention education and health maintenance education on site in D/A programs: -- risk of PADU and alc/drug free status when planning pregnancy --family planning education incl. reproductive health education and risks of unprotected sex (unplanned pregnancy, STDs, HIV), nutrition, and sexuality. --D/A education on natural history on chemical dependency in women incl. physiological impact --information on how to access women's health care services	***Services*** • on-site child care in alc/drug treatment and recovery programs • directly provide or make referrals to pediatric care, child development, infant stimulation, and child development education services	***Services*** • acknowledge presence of partner (male or female) in woman's life and that partner's impact on woman's drinking/use • develop individual *family* service plans, to address grand-parents, partners, and other siblings, as well as treatment plans for primary client • provide referrals for families to needed services • provide support classes and groups for families • offer family alumni groups with alcohol/drug-free activities

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MATRIX IV Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	PARTNERS AND/OR FAMILY
ALCOHOL/DRUG SERVICES	• referrals with case management follow-up *Access* • additional treatment slots (incl. detox, methadone maintenance, treatment and recovery) and support services for nonpregnant women	• education of women at risk about specific county policies re: removal of children, reunification, etc., and counseling on preventing removal of children • D/A providers do risk assessment for D/A use, HIV risk (whether IVDU or not) • program staff should support and encourage pregnant women to enroll in prenatal care while in D/A treatment; encourage on-site PHN visits as bridge between D/A and prenatal services	• public health nurse involvement to begin at labor and delivery for post-delivery follow-up, child care support, education, identification of any problems with child, etc	• coordination with CPS when appropriate, including counseling to prepare for reunification for women with children in foster care • continue public health nurse involvement for postpartum follow-up, child care support, education, identification of any problems with child, etc • parenting and child development education • address co-dependency issues when appropriate (usually no earlier than Year 2 of sobriety)		

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MATRIX IV Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN O TO 3	PARTNERS AND/OR FAMILY
ALCOHOL/DRUG SERVICES		• treatment and recovery services for pregnant women including: - appropriate medical fetal and maternal management of physiological withdrawal (detox) in variety of settings; setting to be determined on case-by-case basis; *no* short-term methadone detox during pregnancy - outpatient services - intensive day treatment -inpatient (hospital-based) pro-grams - residential communities for women - therapeutic communities for women		• treatment and recovery services for women incl: - outpatient services - intensive day treatment -inpatient (hospital-based) programs - residential communities for women - methadone maintenance for women with counseling component - case management by program staff to ensure women's access to needed services		

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MATRIX IV Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN O TO 3	PARTNERS AND/OR FAMILY
ALCOHOL/DRUG SERVICES		- methadone maintenance for pregnant women, with counseling component - aftercare programs for women including 12-step and therapeutic support groups, relapse prevention and support services such as job training and counseling and GED --case management by program staff to ensure women's access to needed services • children's services including child care on-site, provision for residence of children with mothers, parenting classes, child development • family planning services either on or off-site •prenatal and childbirth education either on or off-site		• aftercare programs for women, including 12-step and therapeutic support groups, relapse prevention, job training and counseling, GED, and education for program staff on women's issues in programs that have traditionally been male-oriented • individual therapeutic and/or support group attention to women's issues, including sexual assault/abuse, domestic and other violence • children's services including child care on-site, provision for residence of children with mothers, parenting classes, child development • family planning services either on or off-site		

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MATRIX IV Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PREPREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN O TO 3	PARTNERS AND/OR FAMILY
ALCOHOL/DRUG SERVICES		• development of labor and delivery and parenting plan as part of treatment service plan; to be shared with OB • facilitate women getting tour of labor and delivery suite *Access* • all treatment/ recovery modali-ties available to all pregnant women, including woman-specific services and programs • signed consents with all providers for communication and joint planning		*Access* • all treatment/ recovery modalities available to all women, including woman-specific services and programs • signed consents with all providers for communication and joint planning		

MATRIX V: SOCIAL SERVICES

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	PARTNERS AND/OR FAMILY
SOCIAL SERVICES	***Services*** • full range of social and support services, including: -- economic support services such as General Assistance (GA), AFDC (if woman has other children), Medi-Cal -- Immigration and Naturalization (INS) information -- family violence services -- CPS services including guidance, family maintenance, foster care, and family reunification -- vocational rehabilitation services, GED assistance, and job counseling and training -- child care, including drop-in and respite care	***Services*** • full range of social and support services, including: -- economic suppport services such as General Assistance (GA), AFDC (if woman has other children), Medi-Cal -- Immigration and Naturalization (INS) information -- family violence services -- CPS services including guidance, family maintenance, foster care, and family reunification -- vocational rehabilitation services, GED assistance, and job counseling and training -- child care, including drop-in and respite care	***Services*** • full range of social and support services, including: -- economic support services such as General Assistance (GA), AFDC (if woman has other children), Medi-Cal -- Immigration and Naturalization (INS) information -- family violence services -- CPS services including guidance, family mainten-ance, foster care, and family reunification -- vocational rehabilitation services, GED assistance, and job counseling -- child care, including drop-in and respite care	***Services*** • full range of social and support services, including: -- economic support services such as General Assistance (GA), AFDC , Medi-Cal -- Immigration and Naturalization (INS) information -- family violence services -- CPS services including guidance, family maintenance, foster care, and family reunification -- vocational rehabilitation services, GED assistance, and job counseling -- child care, including drop-in and respite care	***Services*** • full range of social and support services, including: -- economic support services such as Medi-Cal, CHDP, and other health care ser-vices for child -- income support through AFDC and/ or child support • Children of Alcoholics-type intervention services, such as therapy groups, etc., to pick up possible developmental problems • linkage with public health nurses for follow-up referral to services	***Services*** • develop and mobilize plan to link partner and/or family to needed services • use of case management to develop service plan and to assure linkage for woman, child, family • social services should be available and accessible for male/female partners and families

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MATRIX V Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN O TO 3	PARTNERS AND/OR FAMILY
SOCIAL SERVICES	-- parent support services including taped phone information lines, hot/warm lines, and advice lines -- services to support and enhance self-esteem -- financial and daily living skills training -- housing assistance including transition and clean and sober -- transportation to needed services -- legal services and advocacy -- case management if needed	-- parent support services including taped phone information lines, hot/warm lines, and advice lines -- services to support and enhance self-esteem -- financial and daily living skills training -- housing assistance inlcuding transition and clean and sober -- transportation to needed services -- legal services and advocacy -- case management if needed	-- parent support services including taped phone information lines, hot/warm lines, and advice lines -- services to support and enhance self-esteem -- financial and daily living skills training -- housing assistance including transition and clean and sober -- transportation to needed services -- legal services and advocacy -- case management if needed	-- parent support services including taped phone information lines, hot/warm lines, and advice lines -- services to support and enhance self-esteem -- financial and daily living skills training -- housing assistance including transition and clean and sober -- transportation to needed services -- legal services and advocacy -- case management if needed		

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MATRIX V Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	PARTNERS AND/OR FAMILY
SOCIAL SERVICES	*Access* • access to be facilitated by social service coordination with other services, including social service worker visits on-site at programs for eligibility determination and enrollment in services	-- pregnancy counseling including adoption, pregnancy termination, tubal ligation, child-birth support, etc. -- grief counseling as needed re: adoption, abortion, stillbirth, loss of partner, etc. *Access* • access to be facilitated by social service coordination with other services, including social service worker visits on-site at programs for eligibility determination and enrollment in services	-- pregnancy counseling including adoption, pregnancy termination, tubal ligation, child-birth support, etc. -- grief counseling as needed re: adoption, abortion, stillbirth, loss of partner, etc. -- universal assessment for indications for referral to CPS (as per SB 2669) -- social services evaluation for referral to needed services *Access* • access to be facilitated by social service coordination with other services, including social service worker visits on-site at programs for eligibility determination and enrollment in services	-- pregnancy counseling including adoption, pregnancy termination, tubal ligation, child-birth support, etc. -- grief counseling as needed re: adoption, abortion, stillbirth, loss of partner, etc. -- possible need for traditional CPS services, voluntary or involuntary, including reasonable efforts, family reunification *Access* • access to be facilitated by social service coordination with other services, including social service worker visits on-site at programs for eligibility determination and enrollment in services		

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MATRIX VI: PUBLIC HEALTH NURSING

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	PARTNERS AND/OR FAMILY
PUBLIC HEALTH NURSING	*Services* • once woman is referred to PHN (eg, post-identification of health problem): -- PHN to follow up on health-related issues -- provide individual and/or group general health education and promotion -- perform risk assessments, including women's chemical dependency, either at home or in program -- provide family planning counseling, education, referral, and care, at home or in program	*Services* • once woman is referred to PHN (eg, post-identification of health problem): -- PHN to follow up on health-related issues -- provide individual and/or group general health education and promotion -- perform risk assessments, including women's chemical dependency, either at home or in program -- provide family planning counseling, education, referral, and care, at home or in program	*Services* • PHNs to coordinate with hospitals to arrange for PHN involvement post-delivery, including coordination with D/A programs *Access* • PHNs available for referrals from hospital staff for home visits	*Services* • PHN to visit woman in home to assess, provide infant care education, and monitor • family planning follow-up including health education re: STDs and HIV • serve as resource to alc/ drug treatment programs for health classes • continue case management services as needed	*Services* • provide education on infant care, monitor children's growth and devel-opment • make referrals to children's services as appropriate • develop and implement family service plan • coordinate services with other service providers	*Services* • provide partners with education on STDs and HIV • evaluate family situation and share information and coordinate with D/A treatment programs and social services • make referrals to services as needed (eg, vocational rehabilitation, life skills training, etc.)

...cont.

MATRIX VI Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	PARTNERS AND/OR FAMILY
PUBLIC HEALTH NURSING		-- provide prenatal education, childbirth preparation, parenting education, and health monitoring -- provide case management services and referrals, including coordinating services with prenatal care and other providers for unified treatment plan, including co-location of services wherever possible *Access* • public health nursing should provide that *all* pregnant women, regardless of income, receive at least one home visit				

MATRIX VII: OUTREACH

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	PARTNERS AND/OR FAMILY
OUTREACH	***Services*** • media campaign to educate women and men on consequences of alcohol/drug use during pregnancy, including STDs and HIV - campaign to use billboards, TV, radio, and print media - campaign information to include phone numbers of hotlines with information and referrals for linkage to alc/ drug treatment and women's health care	***Services*** • media campaign to educate women and men on consequences of alcohol/drug use during pregnancy, including STDs and HIV - campaign to use billboards, TV, radio, and print media - campaign information to include phone numbers of hotlines with information and referrals for linkage to alc/ drug treatment and prenatal care		***Services*** • media campaign to educate women and men on consequences of alcohol/drug use during pregnancy, including STDs and HIV - campaign to use billboards, TV, radio, and print media - campaign information to include phone numbers of hotlines with information and referrals for linkage to alc/ drug treatment, women's health care and child development services		***Services*** • media campaign to educate women and men on consequences of alcohol/drug use during pregnancy, including STDs and HIV - campaign to use billboards, TV, radio, and print media - campaign information to include phone numbers of hotlines with information and referrals for linkage to alc/ drug treatment, women's health care, and child development services

...cont.

MATRIX VII Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN 0 TO 3	PARTNERS AND/OR FAMILY
OUTREACH	• community outreach re: perinatal, alc/drug, and child develop-ment services, to be provided in multiple sites including schools, housing projects, churches, community health and store-front clinics, family planning, Medi-Cal, AFDC, WIC sites - to reach target population that may not use family planning, community clinics, or social service agencies	• community outreach re: perinatal, alc/drug, and child develop-ment services, to be provided in multiple sites including schools, housing projects, churches, community health and store-front clinics, family planning, Medi-Cal, AFDC, WIC sites - to reach target population that may delay or lack access to prenatal care and to provide re-ferrals to alc/ drug programs		• community outreach re: perinatal, alc/drug, and child develop-ment services, to be provided in multiple sites including schools, churches, community health and store-front clinics, family planning, Medi-Cal, AFDC, WIC sites - to provide information on effects of alc/drug use during pregnancy and referrals to alc/drug programs, women's health care, and child development services		• community outreach re: perinatal, alc/drug, and child develop-ment services, to be provided in multiple sites including schools, churches, community health and store-front clinics, family planning, Medi-Cal, AFDC, WIC sites - to provide information on effects of alc/drug use during pregnancy and referrals to alc/drug programs, women's health care, and child development services

...cont.

MATRIX VII Cont.

STAGES OF SERVICE DELIVERY

CATEGORIES OF SERVICES	PRE-PREGNANCY	PRENATAL	LABOR AND DELIVERY	WOMEN TO THREE YEARS POSTNATAL	CHILDREN O TO 3	PARTNERS AND/OR FAMILY
OUTREACH	• outreach to be provided by community neighborhood workers, cross-trained by professionals to address women's health care, family planning, alc/drug use	• outreach to be provided by community neighborhood workers, cross-trained by professionals to address women's health care, family planning, alc/drug use		- to reach target population that may not use family planning, community clinics, or social service agencies • outreach to be provided by community neighborhood workers, cross-trained by professionals to address women's health care, family planning, alc/drug use children's health care		- to reach target population that may not use family planning, community clinics, or social service agencies • outreach to be provided by community neighborhood workers, cross-trained by professionals to address women's health care, family planning, alc/drug use, children's health care

APPENDIX D

SPECIAL POPULATIONS

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POPULATIONS OF WOMEN AND CHILDREN WITH SPECIAL NEEDS

The model of care panel briefly considered the special needs of several specific populations of women and children, including women and children with HIV, children with other special health needs, women with disabilities, women in jails, and adolescents. All these women and children should have access to the full continuum of care; at the same time, these groups of women and children need additional attention. The panel was unable to give these populations the full discussion they deserve; however, we note below the additional service components and approaches panelists think are important for women and children with special needs.

Women with HIV

- Women with HIV should have access to counseling services and support groups specific to women's issues concerning their HIV status, including attention to grief issues.

- Additional health monitoring, education on how to maintain health, and nutritional counseling should be available.

- Because of the extraordinarily complex multiple needs of women who are pregnant or postpartum, chemically dependent, and HIV positive, special attention should be paid to developing a coordinated service plan with *all* providers with whom the woman is in contact.

Children with HIV

- There should be careful, regular monitoring of the child by a public health nurse or other health care provider to pick up any lags in growth or development or any signs of illness.

- Parents should receive education on how to identify any delays or signs of illness and to report them to health care and other service providers.

- As with women, coordination of services is extremely important for these children, and attention should be paid to developing and implementing a coordinated service plan, including coordination with all physicians and other health providers involved in treating the child.

Children with Other Special Health Needs

- As with those with HIV, these children will need special attention to coordination of services, particularly with physicians and other health care providers.
- Parents should receive education on the special care needs of their children and how to recognize and address problems, as well has training on how to meet their children's health needs.
- These children require careful monitoring to assure that parents, particularly chemically dependent parents, have the skills to properly care for their children and to recognize and address problems as they develop.

Women with Disabilities

- Accessibility remains a major problem for many women with disabilities, including those who are deaf or blind, have developmental disabilities, or have mobility limitations. Alcohol and drug treatment and other services should be available to accommodate women with these disabilities.
- Public health nurses or other case managers should work to link women with existing disability-oriented services in the community, including resources such as attendants, that can assist disabled women to care for their children.

Women in Jails

- Because a large percentage of women in jails have alcohol and drug problems, all pregnant women in jail should be assessed for alcohol and drug use. County alcohol and drug program staff should consider training jail staff to perform these assessments.
- Alcohol and drug treatment and recovery services and prenatal care, including prenatal classes, must be available to women in jails, with a strong linkage to these services on the outside to assure easy access and continuity of care for women following their release.
- Jails should have onsite nurseries to enable newly delivered and parenting women to bond and visit with their children.
- Public health nurses or other case managers should be available to monitor the health, safety, and development of children while their mothers are in jail. They should also follow up with the mothers and children after the woman's release, preferably through a referral to public health nursing.

Adolescents

- The developmental needs of adolescents must be considered in planning and delivering services in addition to issues concerning their pregnancy, parenting, and alcohol and drug use.

- School-based clinics are an important source of providing services to adolescents, often serving as a point of entry into the service system. Clinic staff should receive training in assessing adolescents regarding their prepregnancy and prenatal needs and their risk of alcohol and drug use, including perinatal use.

- Adolescents in juvenile halls, like women in jails, also need access to services, including prevention education on alcohol and drug issues and pregnancy-related education and services.

APPENDIX E

SERVICES CHECKLIST

MODEL OF CARE CHECKLIST*

EDUCATION AND PREVENTION

Education and prevention activities to address the following:	
• risks of perinatal alcohol and drug use for women, fetuses, and children	0 1 2
• physiological impact of drug and alcohol use on women and children	0 1 2
• family planning including reproductive health education, risks of unprotected sex, spacing of pregnancies	0 1 2
• sexuality	0 1 2
• nutrition education	0 1 2
• pregnancy counseling	0 1 2
• parenting and child development	0 1 2
--information appropriate for all parents (e.g., need for regular medical check-ups, immunizations, child development)	0 1 2
--education tailored to needs of drug-exposed children (e.g, infant withdrawal, effective methods for soothing agitated infants)	0 1 2
• access to health and social services, and alcohol and drug treatment and recovery services	0 1 2
• county policies regarding the consequences of alcohol and drug use:	
--removal of children	0 1 2
--reunification of families	0 1 2
--parental actions that can prevent removal of children	0 1 2
Education and prevention available at a wide variety of traditional and non-traditional sites that include:	
• schools	0 1 2
• community health clinics	0 1 2
• drug and alcohol treatment and recovery programs	0 1 2
• community centers	0 1 2
• churches	0 1 2
• other sites	0 1 2
Services provided by health professionals, including PHNs, and community workers in clinics and classes. Flyers and brochures available.	0 1 2

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*Prepared by the Center for the Vulnerable Child and the Youth Law Center, June 1991. See last page of service checklist (p. 80) for an explanation of coding.

MODEL OF CARE CHECKLIST

OUTREACH	
Community-based media campaigns to educate both men and women on	
• the consequences of alcohol and drug use during pregnancy	0 1 2
• the risks of sexually transmitted diseases, including HIV infection	0 1 2
• phone numbers for information and referrals to services, including alcohol and drug treatment and recovery, woman's health care, and child development services	0 1 2
Media strategies to include the use of:	
• billboards	0 1 2
• TV	0 1 2
• radio	0 1 2
• print media	0 1 2
Community neighborhood workers to provide outreach in multiple sites	0 1 2
DSS workers stationed at community health and social service sites to facilitate access to Medi-Cal and social services	0 1 2

MODEL OF CARE CHECKLIST

HEALTH AND PSYCHOSOCIAL ASSESSMENT	
Health and psychosocial assessments to be a routine part of care for *all* women and children not only those suspected of drug and/or alcohol use or exposure. Toxicology screens in and of themselves are not appropriate tools for assessing women's alcohol and drug use during pregnancy.	0 1 2
Screening/assessment to include :	
• questions regarding	
--alcohol and drug use	0 1 2
--sexual/physical abuse	0 1 2
-- HIV risk	0 1 2
--psychiatric needs	0 1 2
• evaluation of the mother/child dyad	0 1 2
• developmental assessment of the child	0 1 2
• evaluation of environmental factors (e.g., housing, other children, caretakers)	0 1 2
• referrals to all appropriate services, including CPS if indicated	0 1 2
• periodic assessment to determine whether referrals to CPS are required to secure family maintenance services or to remove children from unsafe home environments	0 1 2
Screening/assessment to be provided by trained providers including:	
• prenatal care providers, including private physicians, clinics, CPSP providers, nurse midwives	0 1 2
• hospital labor and delivery staff	0 1 2
• public health nurses	0 1 2
• pediatricians	0 1 2
• nurse practitioners	0 1 2
• physician's assistants	0 1 2
• early intervention specialists	0 1 2
• social workers	0 1 2

MODEL OF CARE CHECKLIST

HEALTH AND PSYCHOSOCIAL ASSESSMENT 2

Comprehensive assessments to follow when indicated by screening results:	
• by providers trained in both identification and intervention with women at risk to assess alcohol and drug use	0 1 2
• by early intervention specialists to assess children's developmental needs	0 1 2
• referrals to appropriate services, including CPS if indicated	0 1 2

MODEL OF CARE CHECKLIST

SERVICES	
Family planning services including:	
• complete health history	0 1 2
• comprehensive physical examination and screening exams for high blood pressure, blood tests for anemia and STDs, Pap smears, breast self-examination and if appropriate blood test to detect HIV infection (with a woman's consent)	0 1 2
• contraceptive education	0 1 2
• contraceptives	0 1 2
• referrals for follow-up services	0 1 2
• Services to be provided in health care and non-traditional settings (e.g, churches, street-front clinics, housing projects) with readily available contraceptives which do not require a prescription or medical appointment.	0 1 2
• Services to be sensitive to women's culture, family, and community.	0 1 2
Pregnancy counseling including:	
• information on available options regarding pregnancy	0 1 2
• attention to sexual abuse, incest, domestic violence, co-dependency	0 1 2
• referrals to all appropriate services, including alcohol and drug treatment and recovery and social services	0 1 2
Prenatal and routine gynecological care:	
• PHNs to provide a minimum of one home visit	0 1 2
• services available through a variety of providers including private physicians, CPSP providers, clinics, physicians assistants, nurse practitioners, nurse midwives	0 1 2

MODEL OF CARE CHECKLIST

SERVICES 2	
Labor and delivery services including:	
• social support (provided by dulas, medical social workers, PHNs, perinatal counselors, childbirth educators, etc.)	0 1 2
• development of a service plan to address:	
--discharge	0 1 2
--alcohol and drug treatment and recovery	0 1 2
--social service needs	0 1 2
-- early intervention service needs for the child	0 1 2
-- referrals as needed, including CPS if indicated	0 1 2
• modeling to facilitate mother/infant bonding	0 1 2
• PHN coordination with hospital staff to ensure that at-risk women receive home visits	0 1 2

MODEL OF CARE CHECKLIST

SERVICES 3

Alcohol and drug treatment and recovery services including:	
• aftercare and relapse prevention, including 12-step groups	0 1 2
• intensive day treatment	0 1 2
• inpatient programs	0 1 2
• methadone maintenance	0 1 2
• outpatient services	0 1 2
• residential care	
--residential care for women only	0 1 2
--residential care for women and children	0 1 2
• therapeutic communities	0 1 2
• therapeutic support groups-	0 1 2
Services sensitive to the needs of women and their children which:	
• employ non-confrontational strategies	0 1 2
• address need for child care and child-oriented services by providing on-site care or access to child care services	0 1 2
• provide on-site services or linkages for services to address	
--domestic violence	0 1 2
--sexual assault/abuse	0 1 2
-- co-dependency	0 1 2
--family planning	0 1 2
--pregnancy	0 1 2
--childbirth	0 1 2
--parenting	0 1 2
--child development	0 1 2

MODEL OF CARE CHECKLIST

SERVICES 4

Social services to include:	
• economic support services	0 1 2
• linkage to Medi-Cal, AFDC, CHDP, WIC, and other health and social services	0 1 2
• INS information	0 1 2
• family violence services	0 1 2
• CPS services, including family maintenance and family reunification	0 1 2
• vocational rehabilitation, GED assistance, job counseling and training	0 1 2
• parent support services including support groups to discuss children's' health and behavior problems	0 1 2
• services to support and enhance women's self-esteem	0 1 2
• child care including drop-in and respite services to facilitate access to children's services	0 1 2
• housing assistance	0 1 2
• transportation	0 1 2
• financial and daily living skills training	0 1 2
• pregnancy counseling	0 1 2
• grief counseling, as needed, regarding adoption, abortion, stillbirth, loss of partner	0 1 2
• legal services and advocacy	0 1 2
• case management	0 1 2
Services for partners and families	
• family service plan to address family needs and make referrals to appropriate services	0 1 2
• education for men on	
--women's health and reproduction	0 1 2
--family planning	0 1 2
--dangers of prenatal exposure to drugs and alcohol	0 1 2
--domestic violence	0 1 2
--co-dependency	0 1 2
• classes and groups for families during and following drug and alcohol treatment to offer support and alcohol and drug free activities	0 1 2

MODEL OF CARE CHECKLIST

SERVICES 5	
Services specifically for alcohol and drug-exposed children including:	
• pediatric exams of at-risk newborns shortly after birth to identify possible health problems and 3 to 4 days after birth to identify withdrawal symptoms and other health problems	0 1 2
• on-going well-child health care with consistent provider	0 1 2
• "medical passport" with all relevant medical and psychosocial information	0 1 2
• services by PHN	
--10 home visits during first 6 months and monthly until 12 months	0 1 2
--monitoring of development, feeding patterns, sleep patterns, and mother/child interaction and model parenting	0 1 2
--education regarding child development and developmental milestones	0 1 2
--assessment of family support network	0 1 2
--assessment of mother's social and living skills	0 1 2
referral to services, as needed	0 1 2
• early intervention services	0 1 2
• day care/preschool	0 1 2

MODEL OF CARE CHECKLIST

CASE MANAGEMENT AND COORDINATION	
Case management services to be available for pregnant and post-partum women who use alcohol and other drugs, as well as for young at-risk children, to assure access to and coordination of services.	0 1 2
Casemanagers to work closely with clients who need support to access health, social, and support services and alcohol and drug treatment and recovery services, and to transmit relevant information to child health providers.	0 1 2
Case managers to ensure completion of referrals to drug and alcohol treatment and recovery programs, prenatal care, support services, and CPS when appropriate.	0 1 2
Case managers to be present during discharge planning case conferences following delivery.	0 1 2
Case managers to provide counseling and education.	0 1 2
Case managers of children to continue to age 3 in order to identify developmental delays that may not be evident until after 18 months.	0 1 2
Case managers to refer children to needed services and ensure receipt of referrals	0 1 2

CODE:

0 - Service not available to women or children in the community

1 - Limited availability of services in community; some women and children receive services but it remains unavailable to most eligibles.

2 - Wide availability of services in community; most women and children eligible for services receive them.

APPENDIX F

ASSESSMENT TOOLS

Screening Instrument

Four P's - Parent, Partner, Past, Present

Developed by the Born Free Project
Contra Costa County

The four P's is quick 4 point screen designed to identify women at risk for perinatal chemical dependency. Although this screen is ideally part of assessment of comprehensive prenatal care, it also is effective in the labor and delivery or postpartum setting. The screen reflects self report only. Any positive answer generates a positive screen. The screen is a first level intervention, designed to separate out patients in need of further assessment, education, and possibly referral.

Problem means continued use despite adverse consequences.

1. Parent alcoholic or addict	yes ___	no ___
2. Partner (father of this baby) with problem	yes ___	no ___
3. Past problem with drugs or alcohol	yes ___	no ___
4. Present problem with drugs or alcohol	yes ___	no ___

Assessment interview

The Four Point Counseling Interview

Developed by the Born Free Project
Contra Costa County

The four basic components of a first interview for alcohol and drug dependence are: assessment, education, reality check (review of facts), and referral. These four components can be covered briefly or in depth. Success should be defined by whether the provider has covered all the areas, not whether the patient seems to hear, understand, or accept, or act.

I. Assessment

"Because you have told us you (e.g.): ...have used cocaine in the past, ...had an alcoholic parent, ...have a partner who sometimes uses more than you think he should... etc....I would like to ask you a few more questions about your drug and alcohol use, and give you some information that may help you to protect your baby and yourself."

A. Client's awareness
   1. insight: I have a substance problem? yes, no, maybe.
   2. feelings: guilt, low self esteem, fear, helplessness, desperation.
   3. knowledge: a. fetal and pregnancy effects, b. disease concept, c. genetics, d. recovery resources.

B. Type of involvement with psychoactive substances
   1. substances: cigarettes; options (heroin, methadone, darvon, codeine, etc.); cocaine (crack, rock); methamphetamine (crank, speed, wire); alcohol; marijuana; PCP; prescription; other.
   2. degree of involvement: a. use; b. abuse; use when hazardous; c. dependence: use despite repeated consequences.
   3. activity: active, partial remission; full remission.

C. Context of involvement
   1. family of origin: is client an ACA or from otherwise dysfunctional family? Role of significant family members, especially patient's mother.
   2. father of baby: part of family? using? co-dependent?
   3. attitude towards the baby: blaming others is a symptom of substance abuse. Is she blaming the baby for her problems? Expecting the baby to solve them? Or relating appropriately?
   4. the baby's siblings out of home? healthy?
   5. what services is she involved with that could be coordinated?

II. Education

"Here is some information that you really need to know in order for you to make your own decision about whether you have (are getting) the disease of alcoholism or drug addiction. Everyone should have this information..."

A. We care about you and believe in your ability to change.
Be ever non-judgmental. caring, and positive about recovery.

B. Disease concept:
  1. 3 C's: Compulsion; Control problems; use despite Consequences.
  2. Genetics: generational disease.
  3. Relapsing: even if you stopped you may still have problem.
  4. Recovery: many are recovering; resources are available.

C. Effects of drugs/alcohol and family drug/alcohol abuse on fetus, pregnancy, newborn, and child. Be careful not to shame the patient.

III. Reality check (review facts)

"You have told me that you (e.g.): ...spend more money than you plan to on drugs....have arguments with your partner when you are using...have lost custody of a child in the past because of drugs/alcohol....have been involved with the legal system because of your use, etc. A person simply does not keep doing things that cause such problems unless they have a basic problem with control. I think you may be (are) one of these people."

A. I think you may have a problem because (3 C's) and this could happen because of it.
B. Now that we have talked, do you think you may have a problem
C. Which recovery resources do you want to use at this time?

IV. Referral

A. The more concrete and personal the better (give written material, make phone calls, ask if agency may call her, give names, make appointments). The principle of "attraction" used by AA should become the principle of "aggressive attraction and promotion" for the pregnant or child-rearing addict/alcoholic.

B. Give referrals regardless of whether you or the patient are sure there is a diagnosis of alcohol or drug abuse or dependence. Suspicion is adequate justification. The referrals will probably be used later, if and when the patient is ready, or be used by a friend or family member.
C. Prenatal care provides for extended exposure over time to a given patient. This repeated contact allows for monitoring and

reinforcement of referrals. A woman who is not ready to accept help in the second trimester may be ready as delivery approaches.

D. Patients who are desperate and want help immediately may be given written guidelines on how to proceed through the next 24 hours (see "First Steps" for example).

E. Abrupt withdrawal from opiates, alcohol, and some prescription drugs can occasionally be dangerous for the pregnancy and the fetus. The appropriate medical provider should make recommendations for management of a patient wanting to stop abruptly and immediately.

Five basic guidelines that may facilitate communication

I. Most interviews are uncomplicated
II. Maintain a positive attitude
III. Don't attempt to control or teach control
IV. Don't react to denial and adolescent behavior
V. Family issues are key in interviewing.

I. Most interviews are uncomplicated.

Some of us are apprehensive about interactions with addicts/alcoholics, however the vast majority of patients are cooperative and appreciative of a knowledgeable advocate within the health care system. Only rarely does she refuse to communicate or become antagonistic. Through over 400 interviews done by our project on newly delivered women, only three expressed negativity about speaking with the perinatal alcohol and drug dependence counselor.

II. The most important factor in the interview is your own attitude.

Your attitude of acceptance, caring, positivity, and self confidence is critical to developing trust with the woman. The client/patient will not trust you if you don't trust her to have intelligence and a desire for family health beneath the drug/alcohol problem. You must believe in the reality of recovery yourself in order to project hope. Many providers question whether treatment really helps addicts and alcoholics, and their experience of seeing clients who are in the throes of that disease leads them to feel hopeless. Helpers do not have much contact with those who are succeeding in recovery because they no longer need our services. Recovery does occur, and the support of recovery services does help. Attending open AA, NA, and CA meetings is a good way to gain exposure to healthy recovering people, and to keep your attitudes and beliefs positive.

III. Don't attempt to control or teach control.

If the client is alcohol or drug dependent, remember the goal is not to control her or to help her control her drug or alcohol use. Rather it is to help her accept and work with her inability to control her use, and create an inner and outer lifestyle free of compulsion and drug and alcohol use. Abstinent cocaine addicts who continue to use alcohol relapse to cocaine use at several times the rate of patients with total abstinence. Recovery involves accepting the inability to control and developing a comfortable lifestyle without use of any psychoactive substances. Attempting to help a client with alcohol or drug dependence to control her use is like trying to help someone with tuberculosis control their coughing.

IV. Don't react to denial and adolescent behavior.

A 30 or 40 year old woman who has used drugs/alcohol consistently since early adolescence may think and act like an early adolescent. Denial (honest self-deception) is one symptom of the disease of alcohol/drug dependence. Let the denial emerge and continue the interview.

V. Family issues are key in the interview.

Co-dependency and family of origin issues are key. They are often safer to discuss than drug or alcohol abuse for the client, and lead to the same place as approaching her abuse head on. If the interview stalls, refocus on family of origin, genetic predisposition, or the father of the baby.

RISK ASSESSMENT MATRIX*

Substance-Exposed Infants

FACTOR	LOW RISK	INTERMEDIATE RISK	HIGH RISK
Infant's drug withdrawal symptoms	Withdrawal symptoms not apparent	Mild tremors; sleeps at least 3 hours after feeding; feeding well; normal stools	vomiting; watery stools;fever; sleeps less than 2 hours. after feeding; marked tremors; poor feeding; high pitched cry; seizures; lethargic; on meds. for drug withdrawal
Special medical and/or physical problems	No apparent medical or physical problem	Minor medical or physical problem which do not significantly affect infant's vital life functions or physical intellectual development	Any pre-term infant (born at or before 36 weeks.) and/or physically or medical problems. which significantly impact vital life functions or physical and intellectual development (e.g., cardiac defect, apnea monitor, visual or hearing handicap, seizure disorder)
Special care needs of child	Only routine pediatric care; no special equipment or medication	Monthly pediatric care visits and no medicine or special equipment	Requires 2 or more monthly visits for pediatric care and/or special equipment or medication

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*Prepared in 1989 by Mary Beth Sorensen and Vickie Kropenske, UCLA Drug Project.

RISK ASSESSMENT MATRIX

Parent

FACTOR	LOW RISK	INTERMEDIATE RISK	HIGH RISK
Current drug use	Not currently using any drugs	Occasional 1-2 times per week or weekend use	Use more than two times wk.; any use c PCP or Crack
Drug treatment history	Entered drug treatment. early in pregnancy, remains in program and considered compliant.	Entered drug treatment early in pregnancy, remains in program, but attendance sporadic and/or continues to use drugs	Not in drug treatment program or entered in third trimester.
Prenatal care	Sought early prenatal care and consistent with follow—up	Sought prenatal care in second trimester but inconsistent with prenatal follow-up/medical advise	Did not seek prenatal care until third trimester; or no prenatal care

RISK ASSESSMENT MATRIX

Parent's physical, intellectual, or emotional abilities/control	No intellectual/physical limitation; realistic expectations of child; in full control of mental facilities	Mild physical/emotional handicap; mild intellectual limitations; which would not significantly impact ability to care for child	Moderate to severely handicapped; poor perception of child s behavior; severe intellectual limitations; incapacity due to alcohol/drug intoxication; past criminal/mental illness; poor impulse control (i.e., demonstrated evidence of violence in home)
Parent's level of cooperation	Willingness and ability to work w/agency to resolve problem to protect child	Overtly compliant with investigator and/or presence in home of non-drug using adult to assure minimal cooperation w/agency follow through with medications recommended.	Doesn't believe there is problem; refuses to cooperate; disinterested or evasive
Parent's awareness of impact of drug use on child	Expresses concern/ interest about drugs effect on child sought professional advise counseling	Displays concern/interest in child but denies symptoms and special needs	Displays lack of concern/interest for child denies symptoms

RISK ASSESSMENT MATRIX

Parenting skills and responsiveness to infant	Parent exhibits appropriate parenting skills and knowledge re: special medical follow-up care and is responsive to infant needs		Parent may provide apparent physical care but is unresponsive to infant's needs (i.e., lack of response to crying of infant, poor eye contact, infrequent contacts, inappropriate expectations and criticism of child
History of abuse/neglect	No known history of abuse/neglect	Prior protective services provided to child or sibs with that episode resolved and case closed	Pending child abuse/neglect investigation; previous abuse/neglect of serious nature prior dependency

RISK ASSESSMENT MATRIX

Environmental Factors

FACTOR	LOW RISK	INTERMEDIATE RISK	HIGH RISK
Father or parent substitute in home.	Father or parent substitute in home, who is supportive/stabilizing influence and available to assist with caretaking.	Stable father or parent substitute in home but assumes only minimal caretaking responsibility for child	Father or parent substitute resides with family and has poor impulse control (i.e., demonstrated evidence of violence in home and/or involved in drug activity
Strength of family support systems	Family, neighbors, or friends available and committed to help; membership in church, community, or social group	Family supportive but not in geographic area; some support from friends and neighbors; limited community services available	No relatives or friends available/committed; geographically isolated from community services; no phone; no transportation available
Drug use in home	No member of household suspected to be involved in drug activity		Any one in the household suspected to be involved in drug activity
Sibling assessment (Use Standard Risk Assessment Guide for Sibs)	Education, medical, and environmental, needs being met for all sibs.	Some but not all education, medical, and environmental needs being met for all sibs	Few education, medical and environmental needs being met for all sibs
Environmental condition of home	Home relatively clean with no apparent safety or health hazards; utilities operable; no infestation of rodents; Evidence of preparation for infant's arrival (eg., clothing, furnishings, formula.)	Home relatively clean, but no evidence of preparation for infant's arrival...or vice versa	Home unclean with safety or health hazards; no evidence of preparation for infant's arrival

APPENDIX G

GLOSSARY

GLOSSARY OF TERMS

ADDICTION/CHEMICAL DEPENDENCY	Compulsive use of alcohol and/or other drugs with resulting impairment of physical health, emotional health, social functioning, occupational functioning, or intimate relationships; characterized by overwhelming involvement with alcohol/drugs, compulsive drug-seeking behavior, and high tendency to relapse after abstinence/withdrawal
CASE MANAGEMENT	Strategies that address linkage of services for individuals, including such components as intake and outreach, assessment of client needs, development of an individual care plan, brokering of services, advocacy with programs on behalf of the client, monitoring and follow-up, and evaluation of achievement of the care plan
CO-DEPENDENCY	Disease of relationships in which the self-esteem of one person is regulated by the distorted behavior of another, particularly in relationships in which one partner drinks or uses
CO-LOCATION	Provision of multiple services to clients in a single site
COMPREHENSIVE CARE/ CONTINUUM OF CARE	Provision of multiple services needed by client, either all on-site or coordinated through interdisciplinary teamwork, to meet health, psychosocial, alcohol/drug, and social needs
COORDINATION OF SERVICES	Systemic strategies that address linkages and coordination of services among programs, agencies, and departments
CULTURAL DIVERSITY/ SENSITIVITY/COMPETENCE TRAINING	Education/training to enable staff and programs to address cultural differences among clients, including women and children of color and those who are not English-speaking, so that services are appropriate, accessible, and effective
DETOXIFICATION	Appropriate medical fetal and maternal management of physiological withdrawal; can be offered in variety of settings including hospital-based and social model
DEVELOPMENTAL ASSESSMENTS	Measurement tools used to gauge the physical, emotional, and cognitive status of a developing child; since these assessment tools usually provide normative data, inferences may be made regarding the status of a child's development relative to other children of the same age
EARLY INTERVENTION SERVICES	Agencies and individuals concerned with needs of and services for infants and toddlers from birth to age three who are at risk for developmental problems for any reason; services are available for children's families as well

INPATIENT TREATMENT	Hospital-based alcohol/drug treatment services usually provided for 21-28 days
INTENSIVE DAY TREATMENT	Structured therapeutic services, including individual and/or group counseling, provide for specified number of hours per day (usually 4-8 hours) in alcohol/drug program setting
OUTPATIENT SERVICES	Individual and/or group therapeutic/counseling services provided from one to more hours per week in alcohol/drug program setting
RESIDENTIAL CARE	Alcohol/drug treatment and recovery services provided in 24-hour residential setting for women and/or women with their children; residential care usually last 6 months to one year
THERAPEUTIC COMMUNITY	Alcohol/drug treatment and recovery services provided in 24-hour residential setting for women and/or women with their children; community is alcohol/drug-free; usually lasts 18-24 months
THERAPEUTIC SUPPORT GROUPS	Regularly scheduled recovery support groups with professional leaders, for women in recovery, children of alcoholics/addicts, co-dependents
12-STEP GROUPS (AKA AA, NA, ALANON, ALATEEN, ETC.)	Regularly scheduled recovery support groups using Alcoholics Anonymous model (self-help oriented, voluntary, no official or professional leader), for women in recovery, children of alcoholics/addicts, co-dependents

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